REPORT DOCUMENTATION PAGE

1. AGENCY USE ONLY (leave blank)	2. REPORT DATE	3. REPORT TYPE & DATE COVERED
	November 14, 1996	DoD Instruction 1332.39 DODI-1332.39

4. TITLE & SUBTITLE

Application of the Veterans Administration Schedule for Rating Disabilities

5. FUNDING NUMBERS

6. AUTHOR(S)

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8. PERFORMING ORGANIZATION REPORT NUMBERS

9. SPONSORING/MONITORING AGENCY NAME(S) & ADDRESS(ES)

10. SPONSORING/MONITORING AGENCY REPORT NUMBERS

11. SUPPLEMENTARY NOTES

19970128 339

12a. DISTRIBUTION/AVAILABILITY STATEMENT

Unclassified, Release unlimited.

12b. DISTRIBUTION CODE

13. ABSTRACT (Maximum 200 Words)

This Instruction implements policy, assigns responsibilities, and prescribes procedures, under the authority of DoD Directive 1332.18, for rating disabilities of Service members determined to be physically unfit and who are eligible for disability separation or retirement under Title 10, United States Code.

14. SUBJECT TERMS

15. NUMBER OF PAGES

68 Pages

16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
Unclassified	Unclassified	Unclassified	

DTIC QUALITY INSPECTED 1

Department of Defense
INSTRUCTION

November 14, 1996
NUMBER 1332.39

ASD(FMP)

SUBJECT: Application of the Veterans Administration Schedule for Rating Disabilities

References:
(a) DoD Directive 1332.18, "Separation or Retirement for Physical Disability", November 4, 1996
(b) Title 10, United States Code
(c) DoD Instruction 1332.38, "Physical Disability Evaluation," November 14, 1996
(d) Veterans Administration Schedule for Rating Disabilities (38 CFR, Part 4)
(e) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, and Induction," May 2, 1994
(f) Title 37, United States Code

A. PURPOSE

This Instruction implements policy, assigns responsibilities, and prescribes procedures, under the authority of reference (a), for rating disabilities of Service members determined to be physically unfit and who are eligible for disability separation or retirement under reference (b).

B. APPLICABILITY

This Instruction applies to the Office the Secretary of Defense (OSD) and the Military Departments.

C. DEFINITIONS

Terms used in this Instruction are defined in enclosure 1.

D. POLICY

1. Ratable Disabilities. Disabilities determined to be physically unfitting and compensable under reference (c) shall be assigned a percentage rating.

2. Standard. Chapter 61 of reference (b) establishes the Department of Veterans Affairs'(DVA) Veterans Administration Schedule for Rating Disabilities (VASRD) (reference (d)) as the standard for assigning percentage ratings. The percentage ratings represent, as far as can practicably be determined, the average impairment in civilian occupational earning capacity resulting from certain diseases and injuries, and their residual conditions. However, not all the general policy provisions in Sections 4.1 -

4.31 of the VASRD are applicable to the Military Departments. Many of these policies were written primarily for DVA rating boards, and are intended to provide guidance under laws and policies applicable only to the DVA. This Instruction replaces these sections of of the VASRD. The remainder of the VASRD is applicable except those portions that pertain to DVA determinations of Service connection, refer to internal DVA procedures or practices, or are otherwise specifically identified in Enclosure 2 as being inapplicable.

E. RESPONSIBILITIES

1. The Assistant Secretary of Defense for Force Management Policy, under the Under Secretary of Defense for Personnel and Readiness, shall ensure consistency between this Instruction and DoD Directive 1332.18 (reference (a)) and DoD Instruction 1332.38 (reference (c)).

2. The Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall:

a. Perform, on a periodic basis, such review as is necessary to determine uniform application by the Military Departments of the VASRD as modified by this Instruction.

b. Amend or modify this Instruction, as appropriate, after coordination of any proposed amendment or modification with the Assistant Secretary of Defense for Force Management Policy and the Secretaries of the Military Departments.

c. Review substantive changes proposed by the Military Departments for rating disabilities which affect the uniformity of ratings provided for in this Instruction.

3. The Secretaries of the Military Departments shall ensure their respective physical disability evaluation systems apply the VASRD in accordance with this Instruction.

F. PROCEDURES

1. Essentials of Rating Disabilities

a. The VASRD. The VASRD is primarily used as a guide for evaluating disabilities resulting from all types of diseases and injuries encountered as a result of, or incident to, Military Service. Because of differences between Military Department and DVA applications of rating policies for specific cases, differences in ratings may result. Unlike the DVA, the Military Departments must first determine whether a Service member is fit to reasonably perform the duties of the member's office, grade, rank, or rating. Once a Service member is determined to be physically unfit for further Military Service, VASRD percentage

ratings are applied to the unfitting condition(s). Percentages are based on the severity of the condition(s).

b. Medical Treatment at the Time of Voluntary and/or Mandatory Separation and/or Retirement. Medical and surgical procedures are frequently performed near the end of a Service member's military career. Those are intended to improve a Service member's health. Corrective treatment and convalescence will not be considered as a valid contribution to disability unless unexpected adverse effects occur that are expected to persist after discharge from active duty and are ratable.

c. Failure to Comply with Prescribed Treatment. A Service member's degree of disability may have been aggravated or increased by an unreasonable failure or refusal to submit to medical or surgical treatment or therapy, to take prescribed medications, or to observe prescribed restrictions on diet, activities, or the use of alcohol, drugs or tobacco. The compensable disability rating may be reduced to compensate for such aggravation when the existence and degree of aggravation are ascertainable by application of accepted medical principles, and where it is clearly demonstrated that:

(1) The Service member was advised clearly and understandably of the medically proper course of treatment, therapy, medication or restriction; and

(2) The Service member's failure or refusal was willful or negligent, and not the result of mental disease or of physical inability to comply.

d. Illegal and/or Controlled Substances. The following applies to Unfitting Medical Disorders and/or Conditions that result from the use of Substance Abuse and/or Chemical Dependency:

(1) Illegal and/or Controlled Substances or generally known toxins; e.g., cocaine, PCP, LSD, & heroin: Treat as misconduct unless use was the product of an otherwise unfitting condition.

(2) Other substances, e.g., alcohol and Nicotine: Any physical disability resulting from post Level II or III or equivalent treatment will be considered as Non-Compliance.

e. Objective Medical Findings and Disability Ratings. Physical examination findings, laboratory tests, radiographs and other findings are not, in themselves, ratable. A rating for a disability must be based on demonstrable impairment of function unless otherwise provided in this regulation.

f. Elective Surgery or Treatment. Prior to any elective treatment by the Military Health Services System (MHSS), a Service member must consult with a competent military medical authority. A Service member who elects to have such treatment done at his or

her own expense will not be eligible for compensation under the provisions of this Instruction for any adverse residuals resulting from the elected treatment, unless it can be shown that such election was reasonable or resulted from a significant impairment of judgment that is the product of a ratable medical condition. A record of the counseling will be made by the Health Benefits Advisor or other designated individual to document that the member was counseled about the elective treatment and his or her subsequent ineligibility for disability compensation for any adverse residuals incurred secondary to the elective treatment.

g. Disabilities Not Unfitting for Military Service. Conditions that do not themselves render a Service member unfit for military service will not be considered for determining the compensable disability rating unless they contribute to the finding of unfitness.

h. The Relative Contribution of Non-Compensable Medical Conditions (Condition(s) Not Considered Physical Disabilities) to Current Industrial Impairment of Ratable Neuropsychiatric Conditions. Personality Disorder(s), Impulse Control Disorders, or Substance Use and/or Abuse Disorder(s) are examples of condition(s) not constituting a physical disability that often significantly contribute to, or may be the chief cause of, any industrial and industrially related social impairment suffered by the Service member who has a compensable Neuropsychiatric condition. Unfitting disability resulting therefrom will not be rated. In such instances, the overall rating of psychiatric impairment will be reduced to the impairment rating that would be warranted in the absence of the influence of the non-compensable condition according to generally accepted medical principles. It is imperative that the Medical Evaluation Board (MEB) quantify the contribution of each medical condition to the overall industrial impairment manifested by the Service member.

2. Higher of Two Evaluations. When the circumstances of a case are such that two percentage evaluations could be applied, the higher percentage will be assigned only if the Service member's disability more nearly approximates the criteria for that rating. Otherwise, the lower rating will be assigned. When, after careful consideration of all reasonably procurable and assembled data, there remains a reasonable doubt as to which rating should be applied, such doubt will be resolved in favor to the member.

3. Changes in Rating Criteria. Members on the TDRL shall be rated under the VASRD criteria in effect at the time of their final reevaluation.

4. Pyramiding. Pyramiding is the term used to describe the application of more than one rating to any area or system of the body when the total functional impairment of that area or system is adequately reflected under a single appropriate code. Disability from injuries to the muscles, nerves, and joints of the

extremity may overlap to a great extent. Special rules for their valuation are included in appropriate sections of the VASRD and in enclosure 2 of this Instruction. Related diagnoses should be merged for rating purposes when the VASRD provides a single code covering all their manifestations. This prevents pyramiding and reduces the chance of over-rating. For example, disability from fracture of a tibia involving malunion, limitations of dorsiflexion, eversion, inversion, and subtalar motion, as well as traumatic arthritis of the ankle would be rated using one diagnostic code (5271) that reflects overall ankle function, rather than by adding separate ratings for the limitations of motion and the traumatic arthritis.

5. Total Disability Rating. Total disability will be considered to exist when the member's impairment is sufficient to render it impossible for the average person suffering the same medical condition to engage in a substantially gainful civilian occupation. Accordingly, in cases in which the VASRD does not provide a 100 percent rating under the appropriate (or analogous) code, a member may be assigned a disability rating of 100 percent if the member's impairment is sufficient to render it impossible to engage a substantially gainful occupation.

6. Extra-Schedule Ratings in Exceptional Cases. The requirement to use the VASRD in rating disabilities does not prevent the Secretary of the Military Department concerned from assigning ratings in unusual cases not covered by the VASRD. In such cases, extra-schedule ratings commensurate with the average earning capacity impairment due exclusively to Service-connected disability may be assigned. Such cases must be rated in accordance with procedures established by the Secretary of the Military Department concerned. The basis of the conclusion that the case presents such an exceptional or unusual disability picture that the regular VASRD standards do not apply must be documented.

7. Convalescent Ratings. Under certain diagnostic codes, the VASRD provides for a convalescent rating to be awarded for specified periods of time without regard to the actual degree of impairment of function. SUCH RATINGS DO NOT APPLY TO THE MILITARY DEPARTMENTS. Convalescence will ordinarily have been completed by the time optimum hospital improvement (for disposition purposes) has been attained. If not, rate according to the manifest impairment.

8. Observation Ratings. The VASRD, in cases of malignancy, has ratings applicable for a one to two year period of observation. Following this period of observation residuals will be rated. Observation ratings do apply to the Military Departments.

9. Analogous Ratings. When an unlisted condition is encountered, it is permissible to rate it by analogy to a closely related disease or injury. The unlisted and analogous conditions

should reflect adverse impact upon reasonably similar functions, anatomical structures, or be symptomatically similar. Conjectural analogies, analogous ratings for conditions of doubtful diagnosis, and diagnoses not fully supported by clinical/laboratory findings are not acceptable. Organic diseases or injuries will not be rated by analogy to disorders of psychiatric origin (VASRD codes 9000 - 9511), except when directed by law (e.g., Gulf War cases). (See the Analogous Rating Table, enclosure 3).

10. Zero Percent Ratings and Minimum Ratings

a. Occasionally, a medical condition that causes or contributes to unfitness for military service is of such mild degree that it does not meet the criteria for even the lowest rating provided in the VASRD under the applicable code. A zero percent rating may be applied in such cases even though the lowest rating listed is 10 percent or more, except when "minimum ratings" are specified. The "Bilateral Factor" (see paragraph 13) will be applied when a disability is present in two paired extremities, even though one extremity is rated at zero percent.

b. In some instances, the VASRD provides a "minimum rating," without qualifications as to residuals or impairment. Diagnosis alone is sufficient to justify the minimum rating. Syringomyelia, code 8024, is an example. Although higher ratings may be awarded in consonance with degree of severity, no rating lower than the "minimum" may be used if the diagnosis is satisfactorily established.

c. The VASRD provides a minimum rating for "residuals" in certain medical conditions. A given Instruction may state, "rate residuals, minimum _____ percent," or may specify what impairment to rate and give a minimum rating for that impairment. Examples are code 8011, anterior poliomyelitis, and 6015, benign new growth of eyeball and adnexa, other than superficial. To justify the minimum rating for residuals, a functional impairment or other residual caused by the condition must exist. Otherwise, a zero percent is appropriate if the primary condition is unfitting.

11. Rating of Medical Impairments Existing Prior To Service

a. Permanent Service Aggravation. A medical condition manifesting itself prior to entry into military service will be considered "permanently service aggravated" when military service lastingly worsens that medical condition beyond its natural progression. Generally accepted medical principles will be used to determine "natural progression".

b. No Permanent Aggravation. For service membersfor whom no permanent service aggravation has occurred, no rating will be listed. However, the rationale will state the basis for the determination that the unfitting condition existed prior to service (EPTS) and was not permanently aggravated by service.

When the condition is considered unfitting due to natural progression without permanent service aggravation, the accepted medical principle that supports the finding of "natural progression" will be addressed in all cases for which a rationale for the findings is published.

c. Aggravation and Present Degree of Disability Less than 100 percent. In cases involving service members with permanent service aggravation and a current degree of impairment less than total, the rating will reflect only the degree of disability over and above that existing at the time of entrance into active service. This requirement applies whether the particular condition was noted at the time of entrance into active service or is later determined, upon the evidence of record, to have existed at that time. It is necessary, therefore, to deduct from the present degree of disability the degree of disability, if ascertainable, that existed prior to entrance into active service. In assessing EPTS disability, the full EPTS clinical course of the impairing medical condition will be taken into consideration. Such deduction should be in terms of the rating schedule for the given condition. The deduction will be recorded on the rating sheet. If the degree of disability at the time of entrance into the Military Service is not ascertainable in terms of the schedule, no deduction will be made. The rating sheet will reflect that the EPTS factor is indeterminable, and a zero percent deduction will be made.

d. Aggravation and Present Degree of Disability 100 percent. When permanent service aggravation has occurred and the current degree of disability is 100 percent, the rating sheet will reflect the EPTS factor, but no deduction will be made.

e. Congenital and Hereditary Conditions. Congenital and hereditary conditions that do not manifest symptomatology until after a member enters active duty under orders specifying a period of more than 30 days shall not be considered Service-incurred. These conditions will be presumed service aggravated unless a preponderance of evidence based on accepted medical principles clearly establishes that the condition is solely the time result of the natural progression of the congenital or hereditary condition..

f. Paired Organs Involving EPTS and Service Aggravation. No deduction for EPTS factor will be made when the member is unfit for any of the following situations involving paired organs. However, the rating sheet will reflect the EPTS factor, and that the EPTS deduction is zero (0) percent.

(1) Blindness in one eye as a result of Service-connected disability and blindness in the other eye as a result of non-service connected disability.

(2) Loss or loss of use of one kidney as a result of Service-connected disability and involvement of the other kidney as a result of non-service connected disability.

(3) Total deafness in one ear as result of Service-connected disability and total deafness in the other ear as a result of non-service connected disability.

(4) Permanent Service-connected disability of one lung, rated 50 percent or more disabling, in combination with a non-service connected disability of the other lung.

12. Combined Ratings Table. When a member has more than one compensable disability, the percentages are combined rather than added (except when the VASRD modified by enclosure 2 indicates otherwise). The combined rating is based on the "whole person concept." A person without a medical impairment is considered 100% fit. An unfitting ratable medical impairment renders an individual less that 100% fit. A revised fitness level results. Subsequent impairments are calculated as a percentage basis of the new fitness level that is always less than 100%. Thus, a person having a 60 percent disability is considered to have a remaining efficiency or fitness of 40 percent. If there is a second disability rated at 20 percent, then the person is considered to have lost 20 percent of that remaining 40 percent, (20% x 40% = 8%). Hence, a 60 percent disability combined with a 20 percent disability results in a combined rating of 68 percent, and a 70% rating in the VASRD. The combined rating for any combination of disabilities is always determined by first arranging the disabilities in their exact order of severity and then referring to the Combined Ratings Table in the VASRD in accordance with the following Instructions:

a. Combining Two Percentages. The higher impairment percentage is located in the left-hand column. The combined percentage is found where the row indicating the percentage of the first (higher) impairment intersects with the column headed by the percentage of the second impairment.

b. Combining Three or More Percentages. The first two percentages are combined as indicated in subparagraph 12.a., above. The result is a new impairment percentage that can be combined with a third percentage following the same procedure as in subparagraph 12.a., above. (Example: 50 combined with 30 equals 65. 65 combined with 20 equals 72). If there are additional percentages, the procedure is repeated using the new combined value and the next percentage. Rounding off is not done until the final value has been calculated and converted as described below in paragraph 12.c.

c. Converting a Combined Rating. After all percentages have been combined, the resulting combined value is converted to the nearest number divisible by 10. Combined values ending in 5 are adjusted upward. If the combined value includes a decimal

fraction of 0.5 or more as a result of applying the bilateral factor (see paragraph 13), the fraction is converted to the next higher whole number; otherwise the decimal fraction is disregarded. (Example: If the combined value is 64.5, the fraction is rounded to a combined value of 65, which is adjusted upward to 70. If the combined value is 64.4, the decimal fraction is disregarded and the combined value of 64 is rounded off to 60.)

13. Bilateral Factor. When a partial disability results from injury or disease of both arms, or both legs, or of paired skeletal muscles, the ratings for the disabilities of the right and left paired sides are first combined in the standard manner. Ten (10) percent of the result (called the Bilateral Factor) will be added to the first combined rating before proceeding with further combinations, or converting to degree of disability. The Bilateral Factor is applied to the bilateral disability combination before final combinations with unpaired disabilities are carried out. The rating for a "Bilateral" disability (combined rating plus the Bilateral Factor) is to be treated as one disability rating when arranging multiple impairments in order of severity prior to calculating further combinations. For example, with disabilities evaluated at 60 percent, 20 percent, 10 percent and 10 percent (the two 10s representing bilateral disabilities), the order of severity would be 60, 21 and 20. The 60 and 21 combine to 68 percent and the 68 and 20 to 74 percent, converted to 70 percent as the final degree of disability. (See paragraph 13.b., below, when there is more than one paired disability.)

a. The terms "arms" and "legs" refer to the whole upper and lower extremities respectively. Thus, when there is a compensable disability of the right thigh (for example, amputation), and of the left foot (for example, amputation of the great toe), the Bilateral Factor applies. Similarly, the Factor is applied whenever there are compensable disabilities affecting use of paired extremities regardless of location or specified type of impairment, except as noted in paragraph 13.c., below.

b. The correct procedure when applying the Bilateral Factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the four extremities in order of their individual severity and apply the Bilateral Factor by adding 10 percent to the total combined value thus attained.

c. The Bilateral Factor is not applicable unless there is an unfitting disability in each of two paired extremities or paired skeletal muscles. Special instructions regarding the applicability of the Bilateral Factor are provided in various parts of the VASRD. For example, codes 7114 - 7117 and codes 8205 - 8412. The Bilateral Factor is not applicable in skin disabilities rated under code 7806.

14. Use of VASRD Codes. The VASRD code number appearing opposite a listed disability indicates the basis of the assigned valuation. Code numbers are also used for statistical analysis upon which policy decisions may be made. Great care must be exercised in the selection of the applicable code and in its citation on the rating sheet.

a. Each rated disability is assigned a single code number unless a hyphenated code is expressly authorized. It is not proper to use additional codes as a means of further describing defects except as authorized by the VASRD (e.g., in Gulf War cases). The written diagnosis entered on the rating sheet should include any description considered necessary to indicate the extent, severity or etiology of the coded condition.

b. Injuries are generally assigned codes that reflect the residual condition on which the rating is based.

c. Diseases are generally coded directly by the number assigned to the disease itself. If the rating is determined on the basis of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus, atrophic (rheumatoid) arthritis rated as ankylosis of the lumbar spine would be "5002-5289." The percentage rating in such cases is reflected in the second number ("5289" in the example). In this way, the basis of each rating can be easily identified.

d. Hyphenated codes are used only:

(1) When the VASRD provides that a listed condition is to be rated as some other code; e.g., myocardial infarction rated as arteriosclerotic heart disease (7005-7006) or nephrolithiasis rated as hydronephrosis (7508-7509).

(2) When the VASRD provides for a "minimum rating" and the disability is being rated on residuals; e.g., multiple sclerosis rated as incomplete paralysis of all unilateral upper extremity radicular groups (8018-8513) in which case the minimal rating will be 30%.

(3) When an unlisted condition is rated by analogy, e.g., spondylolisthesis rated as sacroiliac injury and weakness (5299-5294). If an unlisted disease, injury, or residual condition is encountered, requiring rating by analogy, the diagnostic code number will be "built-up" as follows: The first two digits will be selected from that part of the schedule most closely identifying the part, or system, of the body involved; the second two digits will be "99." The resulting four-digit number will be connected by hyphen to the code for the analogous condition. This procedure facilitates monitoring of new and unlisted conditions. (See Table of Analogous Ratings, enclosure 3).

(4) The DVA has prepared special analogous ratings for "undiagnosed symptom complexes" associated with Gulf War service. (See Appendix of the Table of Analogous Ratings.)

e. In the narrative citation of disabilities on rating sheets, the diagnostic terminology may be any combination of the medical examiner's or VASRD terminology which accurately reflects the degree of disability. Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease.

15. Rating principles for specific disabilities. Enclosure 2 provides instructions and explanatory notes for rating certain disabilities. This guidance will be followed unless a subsequent change to the VASRD makes the guidance obsolete.

G. EFFECTIVE DATE

This Instruction is effective immediately.

Edwin Dorn
Under Secretary of Defense for
Personnel and Readiness

Enclosures - 3
1. Definitions
2. Special Instructions and Explanatory Notes
3. Table of Analogous Codes

DEFINITIONS

1. Accepted Medical Principles. Fundamental deductions, consistent with medical facts that are so reasonable and logical as to create a virtual certainty that they are correct.

2. Accession Standards. Physical standards or guidelines that establish the minimum medical conditions and physical defects acceptable for an individual to be considered eligible for appointment, enlistment or induction into the military Services (DoD Directive 6130.3, reference (e)).

3. Active Duty. Full-time duty in the active Military Service of the United States. It includes:

a. Full-time National Guard Duty.

b. Annual training.

c. Attendance while in active Military Service at a school designated as a Service school by law or by the Secretary of the Military Department concerned.

d. Service by a member of a Reserve component ordered to active duty (with or without his or her consent), or active duty for training (with his or her consent), with or without pay under competent orders.

4. Active Duty for a Period of More than 30 Days. Active duty or full-time National Guard Duty under a call or order that does not specify a period of 30 days or less.

5. Active Reserve Status. Status of all Reserves who are not on an active-duty list maintained under Section 574 or 620 of 10 U.S.C. (reference (b)), except those in the inactive National Guard or on an inactive status list or in the Retired Reserve. Reservists in an active status may train with or without pay, earn retirement points, and may earn credit for and be considered for promotion. In accordance with the Reserve Officer Personnel Management Act (ROPMA), a member in an Active Reserve status must be on the Reserve Active Status List (RASL)(10 U.S.C. 14002, reference (b)).

6. Active Service. Service on active duty or full-time National Guard duty.

7. Compensable Disability. A medical condition determined to be unfitting by reason of physical disability and which meets the statutory criteria under Chapter 61 of reference (b) for entitlement to disability retired or severance pay.

8. Competency Board. A board consisting of at least three medical officers or physicians (including one psychiatrist) convened to determine whether a member is competent (capable of making a rational decision regarding his or her personal and financial affairs).

9. Death. A determination of death must be made in accordance with accepted medical standards and the laws of the State where the member is located or the military medical standards in effect at an overseas location.

10. Deployability. A determination that the member is free of a medical condition(s) that prevents positioning the member individually or as part of a unit, with or without prior notification to a location outside the Continental United States for an unspecified period of time.

11. Duty Related Impairments. Impairments which , in the case of a member on active duty for 30 days or less, are the proximate result of, or were incurred in line of duty after September 23, 1996, as a result of:

a. performing active duty or inactive duty training;

b. traveling directly to or from the place at which such duty is performed; or

c. after September 23, 1996, an injury, illness, or disease incurred or aggravated while remaining overnight, between successive periods for purposes of IDT, at or in the vicinity of the site of the IDT, if the site is outside reasonable commuting distance of the member's residence..

11. Extended Active Duty. Active duty under orders specifying a period of more than 30 days.

12. Final Reviewing Authority. The final approving authority for the findings and recommendations of the PEB.

13. Full and Fair Hearing. A hearing held by a board, before which the Service member has the right to make a personal appearance with the assistance of counsel and to present evidence in his or her behalf.

14. Impairment of Function. Any disease or residual of an injury that results in a lessening or weakening of the capacity of the body or its parts to perform normally, according to accepted medical principles.

15. Inactive Duty Training (IDT). Duty prescribed for Reservists, other than active duty or full-time National Guard Duty, under 37 U.S.C. 206 (reference (f)) or other provision of law. It does not include work or study in

connection with a correspondence course of a Uniformed Service.

16. Instrumentality of War. A vehicle, vessel, or device designed primarily for Military Service and intended for use in such Service at the time of the occurrence of the injury. It may also be a vehicle, vessel, or device not designed primarily for Military Service if use of or occurrence involving such a vehicle, vessel, or device subjects the individual to a hazard peculiar to Military Service. This use or occurrence differs from the use or occurrence under similar circumstances in civilian pursuits. There must be a direct causal relationship between the use of the instrumentality of war and the disability, and the disability must be incurred incident to a hazard or risk of the service.

17. Line of Duty Investigation. An inquiry used to determine whether an injury or disease of a member performing military duty was incurred in a duty status; if not in a duty status, whether it was aggravated by military duty; and whether incurrence or aggravation was due to the member's intentional misconduct or willful negligence.

18. Natural Progression. The worsening of a pre-Service impairment that would have occurred within the same timeframe regardless of Military Service.

19. Nonduty Related Impairments. Impairments of members of the Reserve components that were neither incurred nor aggravated while the member was performing duty, to include no incident of manifestation while performing duty which raises the question of aggravation. Members with nonduty related impairments are eligible to be referred to the PEB for solely a fitness determination but not a determination of eligibility for disability benefits.

20. Office, Grade, Rank, or Rating.

a. Office. A position of duty, trust, authority to which an individual is appointed.

b. Grade. A step or degree in a graduated scale of office or military rank that is established and designated as a grade by law or regulation.

c. Rank. The order of precedence among members of the Armed Forces.

d. Rating. The name (such as "Boatswain's Mate") prescribed for members of an Armed Force in an occupational field.

21. Optimum Hospital and Medical Treatment Benefits. The point of hospitalization or treatment when a member's progress appears to be stabilized; or when, following administration of essential initial medical treatment, the patient's medical prognosis for being capable of performing further duty can be determined.

22. Performing Military Duty of 30 days or less. A term used to inclusively cover the categories of duty pertaining to 10 U.S.C. 1204 - 1206 (reference (b))(active duty, IDT, and travel directly to and from active duty or IDT).

23. Permanent Limited Duty. The continuation on active duty or in the Ready Reserve in a limited duty capacity of a Service member determined unfit as a result of physical disability evaluation or medical disqualification.

24. Physical Disability. Any impairment due to disease or injury, regardless of degree, that reduces or prevents an individual's actual or presumed ability to engage in gainful employment or normal activity. The term "physical disability" includes mental disease, but not such inherent defects as behavioral disorders, adjustment disorders personality disorders, and primary mental deficiencies.

25. Preponderance of Evidence. That evidence that tends to prove one side of a disputed fact by outweighing the evidence on the other side (that is, more than 50 percent). Preponderance does not necessarily mean a greater number of witnesses or a greater mass of evidence; rather, preponderance means a superiority of evidence on one side or the other of a disputed fact. It is a term that refers to the quality, rather than the quantity of the evidence.

26. Presumption. An inference of the truth of a proposition or fact, reached through a process of reasoning and based on the existence of other facts. Matters that are presumed need no proof to support them, but may be rebutted by evidence to the contrary.

27. Presumption Period. The designated time frame that requires application of the Presumption of Fitness Rule to a member's physical disability evaluation.

28. Proximate Result. A disability the result of, arising from, or connected with active duty, annual training, active duty for training, or inactive duty training (IDT), (etc.) to include travel to and from such duty or remaining overnight between successive periods of inactive duty training. Proximate result is a statutory criteria for entitlement to disability compensation under Chapter 61 of 10 U.S.C.(reference (b)) applicable to Reserve component members who incur or aggravate a disability while performing an ordered period of military duty of 30 days or less.

29. Ready Reserve. Units and individual reservists liable for active duty as outlined in Sections 12301 (Full Mobilization) and 12302 (Partial Mobilization) of reference (b). This includes members of units, members of the Active Guard Reserve Program, Individual Mobilization Augmentees, Individual Ready Reserve, and the Inactive National Guard.

30. Retention Standards. Physical standards or guidelines which establish those medical conditions or physical defects that may render a Service member unfit for further Military Service and are therefore cause for referral of the member into the DES.

31. Service Aggravation. The permanent worsening of a pre-Service medical condition over and above the natural progression of the condition caused by trauma or the nature of Military Service.

SPECIAL INSTRUCTIONS AND EXPLANATORY NOTES

A. GENERAL

1. This enclosure is a supplement to the VASRD that contains principles for rating disabilities where additional guidance or clarification is needed for processing active duty and Reserve military disability cases. Portions requiring special comment, or that have been the cause of misunderstanding in the past, are included. Comments and rating instructions also supplement the VASRD in those instances in which recent medical advances are inadequately covered. Supplements to the VASRD published by the DVA following the effective date of this Instruction shall take precedence unless the changes included in the supplement are identified by the Assistant Secretary of Defense for Health Affairs through a published interim change to this Instruction to be inappropriate to military requirements.

2. In adjudicating cases, the VASRD is the starting point and initial guidance for an impairment rating. Because this enclosure modifies selected VASRD ratings, it is the final reference for impairment adjudications.

3. Unless otherwise directed, separate disability ratings are combined rather than mathematically summed.

B. NEW GROWTHS, MALIGNANT

1. The policies contained in this paragraph apply to malignant new growths except as modified by notes for specific tumors. Special consideration must be given to determination of fitness or unfitness, since many Service members are not disabled by these diseases, their treatment, or the outcome.

2. A Service member with a diagnosed malignant tumor that has metastasized, and has not FAVORABLY responded to therapy, if unfit, SHALL be permanently retired, at 100 percent if such rating is not expected to change within the next 5 years. In such cases, metastasis may be defined as distant spread of the tumor or as local invasion that renders treatment non-curative.

3. A Service member with a diagnosed malignant tumor that has not metastasized and has responded favorably to therapy to the extent that no current evidence of the disease exists, NEED NOT BE FOUND UNFIT . A Service member who is functionally unfit because of residual conditions secondary to treatment of a malignancy (e.g., chemotherapy, radiation therapy, and surgery) may be rated using the Alphabetical Listing of Analogous Ratings (enclosure 3). The code for the relevant malignancy should be listed first, followed by the analogous code(s). For example, the code for leukemia in remission associated with fatigue secondary to chemotherapy would be "7703-6399-6354." Residuals

shall be rated according to the applicable VASRD code and not necessarily according to the code for malignancy. The minimal rating for the malignancy does not apply.

4. A Service member who is undergoing chemotherapy that constitutes the whole or part of definitive treatment may be retained on active duty, placed on TDRL, or permanently retired or separated, as indicated by individual circumstances.

5. When chemotherapy is used as an adjunctive treatment and no evidence of an unfitting residual malignant tumor exists, the use of chemotherapy will not necessarily influence the disposition of the case unless adverse effects of the chemotherapy have ensued.

6. Malignancies, including the leukemias, that require bone marrow transplantation usually result in a Service member being unfit and placed on the Temporary Disability Retired List (TDRL) to be reevaluated at 18 months, or sooner if required. A disability rating awarded after a TDRL interim evaluation shall be based on residual conditions. If recurrent tumor is found, permanent retirement at the appropriate disability rating disability is indicated.

C. ORGAN TRANSPLANTS

1. Joint prosthetic transplants are discussed under codes 5051 through 5056.

2. Vascular system prosthetics are addressed under the 7000 code.

3. Service members requiring transplant will ordinarily be unfit due to organ failure. The Service member should be placed on the TDRL. In those cases in which a definite date has been set for transplantation, disposition shall be postponed and residuals rated after the transplantation.

4. Those cases that have not come before the PEB before transplantation shall be rated based on the following factors:

a. The functional status of the transplanted organ.

b. The need for sustained immunosuppression or its adverse effects. Adverse effects may be rated on the basis of specific infections or by analogy (see enclosure 3: Table of Analogous Ratings).

D. ANTICOAGULANT PROPHYLAXIS OR TREATMENT

1. The long-term use of anticoagulants will not be the cause to increase the rating of a given medical impairment.

2. Complications arising from the use of anticoagulants should be given separate ratings.

3. Hypercoagulable states requiring chronic use of anticoagulants shall be rated either at:

a. Zero percent if there has been no thrombophlebitis or embolus in the past year; or,

b. At least 10 percent if there has been thrombo-phelebitis or embolus in the past year.

c. A rating greater that ten percent shall be based on unfitting residuals due to thrombophlebitis or embolus.

E. HUMAN IMMUNODEFICIENCY VIRUS INFECTION (HIV) AND/OR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). Members found unfit for HIV and/or AIDS will be rated according to the 6351 code and the rating scheme in the VASRD. The minimum rating of 30 percent, which existed prior to the establishment of the VASRD Code 6351, is no longer in effect.

F. GULF WAR CASES

1. Military personnel who served in the Southwest Asia theater of operations (from August 2, 1990, through a date to be determined) and who are unfit for a diagnosis of "undiagnosed illness" shall be rated in accordance with the VASRD rating guidance for "undiagnosed illnesses."

2. A two-part hyphenated code is used to describe the unfitting condition. The FIRST PART is composed of a prefix of "88" combined with the first two numbers of the body system to which the unfitting symptoms most closely relate. The SECOND PART of the code is the medical condition, in the code series indicated by the second two numbers of the first part of the code, that most closely resembles the Service member's circumstances. For example, the first part of the code to describe a case in which the predominant symptom is fatigue could be 8863. The second part is the medical condition in the 6300 series that most closely resembles that of the Service member. In that example, the code "6354" is used. Thus, the case is rated by analogy to "Chronic Fatigue Syndrome." The resulting code is "8863-6354".

3. Two requirements must be met to justify using the coding system described in paragraph F.2., above.

a. The Service member is suffering a symptom complex that is not reasonably definable using currently acceptable diagnostic nomenclature (an "undiagnosed symptom complex"); and,

b. The Service member is unfit because of the "undiagnosed symptom complex."

G. NECROTIZING FASCIITIS

1. Those cases in which the condition has a systemic effect should be rated according to the Alphabetical Listing of Analogous Ratings (enclosure 3).

2. If the systemic component has overwhelmed the Service member's endogenous immune system, the disability should be rated at 100 percent and the Service member placed on the TDRL. Ratings at final disposition shall be based on residuals.

H. Service members with cardiac, vascular or neurosurgical conditions that require indwelling foreign bodies (e.g., pacemakers, defibrillators, venous umbrellas, and venrticulo-peritoneal shunts) who are unfit should be rated at a minimum of 30%.

I. FIBROMYALGIA

1. This condition must be evaluated by a rheumatologist and meet the requirements of paragraph A.5.(b)., below.

2. The diagnostic criteria put forth by the American College of Rheumatology must be met.

J. As medicine advances, new diagnoses will emerge. Those diagnoses generally accepted by the medical profession (or by a respectable minority of the profession) shall be rated by analogy until the diagnoses become incorporated in the VASRD.

Attachment
Instructions for Specific VASRD Codes

INSTRUCTIONS FOR SPECIFIC VASRD CODES

A. 5000 Series

1. 5000. Osteomyelitis

a. Saucerization or sequestrectomy does not necessarily equate with stabilization or cure.

b. Osteomyelitis extending into a major joint is rated in accordance with the amputation rule.

2. 5002. Rheumatoid Arthritis

a. Active process: The rating is based on clinical and laboratory features and coded under 5002.

b. Chronic residuals are rated under appropriate limitation of motion codes (5200 series). Chronic residuals shall be based on clinical features plus radiographic evidence.

c. The bilateral factor is applied when appropriate.

d. Ratings for active disease process (5002) should not be combined with ratings for residuals (5200 series).

e. Pulmonary involvement is rated separately under 6802.

f. Enteropathies are rated separately under the 7300 series.

3. 5003. Arthritis, Degenerative, Hypertrophic, and Pain Conditions Rated by Analogy to Degenerative Arthritis

a. Each major joint (or grouping of minor joints) with objective limitation of motion plus radiographic evidence is rated at 10 percent. (The bilateral factor applies.)

b. Radiographic evidence of two or more major joints or groups of minor joints, when accompanied by occasional exacerbations of incapacitating symptoms, is given a total rating of 20 percent. Radiographic evidence alone without symptoms is rated at 10 percent. (No Bilateral Factor applies).

c. Limitation of motion of affected joints may warrant rating under 5200 series or 9905. (Bilateral Factor applies).

d. In cases in which there is a limitation of motion not of sufficient degree to rate under the 5200 series or 9905, the rating shall be done under 5003.

e. For rating purposes, combinations of interphalangeal, metacarpal-phalangeal, and metatarsal-phalangeal joints are groups of minor joints equivalent to a major joint.

f. 5285-5295. The spine: Each segment of the spine (cervical, dorsal, and lumbar) segments is regarded as a group of minor joints. Combination of sacroiliac and lumbosacral joints is regarded as a major joint. Each group of minor joints is ratable as one major joint only when separate ratings are justified by Radiographic evidence of pathology besides limitation of motion or other evidence of painful motion of the individual segments involved.

4. 5004-5009-5017-5024. Arthritis, Miscellaneous. 5004-5009-5017 are rated according to Code 5003. The remainder, including all of the septic, infectious, or other arthritides, are rated on the basis of associated constitutional symptoms according to VASRD codes 5002. Reiters syndrome, spondylitis, transplantation antigen-related arthritis, or arthritis secondary to bowel disease are examples.

5. 5025. Fibromyalgia

a. Fibromyalgia (also called fibrositis, myofascial pain syndrome, or primary fibromyalgia syndrome), is a syndrome of chronic, and widespread musculoskeletal pain associated with multiple tender or "trigger" points, and is often accompanied by multiple somatic complaints. It is a condition for which diagnostic criteria were formally established in 1990.

b. Diagnostic criteria include the following:

(1) A history of widespread pain that has been present for at least 3 months. There must be both axial skeletal pain and peripheral pain.

(2) The presence of pain on digital palpation at 11 of 18 tender point sites.

(3) The presence of a second clinical disorder does not exclude the diagnosis.

(4) That diagnosis should have been made by or with the consultation of a rheumatologist.

6. 5051-5056. Prosthetic Implants

a. Those do not necessarily render a Service member unfit.

b. If a Service member is considered to be unfit at the time of a Physical Evaluation Board, placement on TDRL should be considered.

c. If the Service member is still found to be unfit at TDRL reevaluation, a permanent rating should be considered based on residual impairment. In such cases the amputation rule applies, but convalescent ratings do not apply.

7. 5126-5151. Multiple Finger Disabilities. A convenient method of computation has made the difficulty often encountered in rating multiple finger disabilities simpler. An "average amputation level" for fingers involved may be calculated by assigning graded values for each finger according to the level at which it was amputated (See Table 1 and Plate III). Graded values may also be assigned for the severity of a finger's ankylosis. The disability may then be rated according to the notes of instruction in the VASRD. The method is as follows:

a. Step One. The appropriate grade value for each of the individual finger defects is selected by referring to figure 1 and by matching the appropriate description in column A of table 1 with the corresponding value in column C. These values are ADDED together (totaled).

b. Step Two. The average grade value is found by dividing the totaled values for the individual fingers by the number of fingers involved. Fractions are rounded to the nearest whole number.

c. Step Three. The category of defects (favorable ankylosis, unfavorable ankylosis, and amputation) applicable to the multiple finger disabilities taken as a whole is found in column B by matching with the previously calculated average grade value in column C.

d. Step Four. The correct disability percentage rating is arrived at by referring to the VASRD code that addresses the category of defects found in step three and calculating for the number of fingers involved.

e. Example: An evaluee has had the following amputations: thumb amputated through the middle phalanx; index and little fingers through the middle phalanges; and the entire ring finger, including more than one-half of the metacarpal.

Grade Value for the thumb	2
Grade Value for index finger	2
Grade Value for little finger	2
Grade Value for ring and metacarpal	4
Total Value	10

Total value/Number of fingers involved = ratable value
10/4 = 2 1/2 = 3

Referring to table 1, grade 3 is ratable as amputation. Amputation of four fingers (thumb, index, ring, and little) is ratable under VA code 5127 at 70 percent for major hand, or 60 percent for minor hand.

f. For rating purposes, the thumb is regarded as having no distal phalanx. Amputation of the thumb at or distal to the interphalangeal joint shall be graded as unfavorable ankylosis (grade value 2).

8. 5171. Amputation of Great Toe. Must be through the proximal phalanx to warrant a 10 percent rating.

9. 5200-5295. Rating Involving Joint Motion

a. In measuring joint motion it is incumbent on the medical examiner to utilize the standardized description portrayed in figures 2 and 3.

b. When the reported limited range of motion falls between two points specified in the VASRD, the higher percentage of disability is applied.

c. Ankylosis is the absence of motion of a joint. For disability rating purposes, it is complete fixation, or a limitation of motion so severe in degree that the amount of movement is negligible.

d. Use of analogies such as "other impairment of" elbow or knee (code 5209 or 5257), is to be avoided when the actual impairment is a limitation of motion of the joint, properly ratable as limitation of flexion or extension of the part distal to the joint.

e. In some cases of limitation, or of other abnormal joint motion, the basic cause is injury to muscle or tendon rather than to bone or joint. A careful distinction must be made for appropriate rating.

10. 5205-5208. Ankylosis or Limitation of Motion of Elbow and Forearm

a. 5205. When a rating for unfavorable ankylosis is not based on the additional finding of complete loss of supination or pronation, the rating may be combined with 5213, subject to the amputation rule. If less then complete loss of supination or pronation occurs, 5205 may be combined with 5213, but the percentage must not exceed the rating for unfavorable ankylosis under 5205.

b. 5206-5208. These codes may be combined with 5213, but the percentage must not exceed the rate for unfavorable ankylosis under 5205. If residuals exceed the maximum rating allowable under 5205 or 5209, the rating for amputation below insertion of the deltoid (5122) may be used.

c. Codes 5209-5212 should not be combined with code 5213.

11. 5213. Impairment of Pronation and Supination

a. The following terminology for describing measurements of pronation and supination must be used, when assessing impairment, to facilitate uniformity of disability ratings.

(1) The STARTING POINT for all motions of pronation and supination shall be zero degrees (thumb on the upper side of the hand with the hand held perpendicular to a flat surface). Supination is that motion between the starting point and palm up position. Pronation is that motion from the starting point to palm down.

(2) Full supination is 80 degrees of motion from the starting point. Full pronation is 80 degrees of motion from the starting point.

(3) Position of function is 20 degrees pronation (AMA guide).

b. VASRD rating 5213.

(1) The hand is fixed in full supination with the palm up.

(2) Hyperpronation continues beyond the 80 degrees of full pronation with the thumb down.

(3) The hand fixed in full pronation is fixed with palm down.

(4) The VASRD term "middle of arc" is equivalent to zero degrees.

(5) The VASRD term "beyond the last quarter of the arc" is equivalent to the inability to pronate beyond 40 degrees from the starting point.

c. Limitation of either pronation or supination may be rated. However, both should never be rated in the same arm. The higher rating applies.

12. 5214. Wrist, Ankylosis of

a. Ankylosis of the wrist in 10 degrees to 30 degrees of dorsiflexion shall be considered favorable and rated accordingly.

b. Wrist replacement prostheses are rated according to functional impairment.

13. 5215-5253. Limitation of Extension and Flexion of the Thigh. Ratings allowable under those codes may not accurately reflect the degree of disability in circumstances where limitation of motion may reflect a more serious underlying disability of the sacroiliac region, pelvis, acetabulum, or head of the femur. The variability of residuals following injuries to these structures necessitates rating specific residuals; e.g., faulty posture, limitation of motion, muscle injury, painful motion of the lumbar spine, mild to moderate sciatic neuritis, peripheral nerve injury, or limitation of hip motion. More suitable ratings may be

selected from VA code 5250 (hip, ankylosis of), VA code 5255 (femur, impairment of, with hip disability), or VA code 5294 (sacroiliac injury).

14. 5255-5262. Defects of Long Bones of the Lower Extremity. These codes (malunion with adjacent joint disability) should be applied when appropriate, to avoid multiple codes and ratings. When both a proximal and a distal major joint are affected, however, an additional rating may be indicated for the less disabled joint. Those codes are often appropriate when joint surfaces are included in fracture lines.

15. 5257. Knee, Other Impairments

a. Patellectomy, chondromalacia, osteochondritis dissecans should be rated under 5003. Exceptions are cases in which objective findings warrant rating under code 5257.

b. Recurrent subluxation or external instability.

(1) A rating of 30 percent for severe knee instability is awarded in those cases where a Lachman's test of ligament instability-to-stress test reveals a reading in excess of 3+ and where a knee brace, usually a derotation brace, is prescribed for a functional as opposed to a protective purpose. Specifically, a functional knee brace supplements or replaces the function of a major ligament or ligaments required for stability. Laxity in a effected knee must be compared to that of the unaffected knee to determine deviation caused exclusively by the medical condition.

(2) A rating of 20 percent for moderate instability is awarded in those cases where the Lachman's test measures an instability reading of 2+ and physical therapy results in no improvement of the knee's lateral instability.

(3) A rating of 10 percent for slight knee instability is appropriate in cases where the Lachman's test measures an instability reading between 1+ and 2+ and physical therapy does not improve the knee's lateral instability.

(4) Knee joint replacement shall be rated according to code 5055.

16. 5285-5295. The Spine

a. Each segment of the spine (cervical, dorsal, and lumbar) segments is regarded as a group of minor joints. Combination of sacroiliac and lumbosacral joints is regarded as a major joint. Each group of minor joints is ratable as one major joint only when separate ratings are justified by radiographic evidence of pathology besides limitation of motion or other evidence of painful motion of the individual segments involved.

b. Arthritic impingement on nerve roots produces degeneration of the nerve function or frequent, prolonged attacks of neuralgia. These attacks are to be distinguished from brief episodes of radicular pain. The arthritic impingement should be rated as one entity under codes for neurologic conditions. The exception is a case in which limitation of spinal motion justifies an additional rating.

17. 5285. Residuals of Fracture of Vertebra

a. The need for a Service member to wear some type of brace to restrict lumbar or dorsolumbar movement is not similar to the requirement for a jury mast type of neck brace for abnormal mobility after cervical fracture. When no cord involvement is evident, the disability should be rated according to the degree of limited motion with brace in place.

b. The 10 percent addition to the rating is made only for demonstrable, substantial deformity of a vertebral body (i.e., visible to the naked eye and greater than 50 percent compression on a X-ray). It should not be added in those instances of insignificant deformity such as slight shortening of the anterior vertical dimension of the vertebral body. When a successful spinal fusion has been performed because of the deformity, the degree of instability has usually been removed, or so far reduced that the addition of 10 percent is not justified. An extensive spinal fusion may result in a ratable limitation of motion.

18. 5286-5289. Ankylosis of a Spinal Segment

a. A rating for ankylosis is given only when the range of motion of the whole spinal segment is absent or negligible. Ankylosis of a part of a segment may leave some degree of useful motion for the segment as a whole. In such cases the appropriate rating would be for limitation of motion.

b. The combination of separate ratings for ankylosis of a spinal segment shall not exceed 60 percent of the rating for complete ankylosis of the spine at a favorable angle.

19. 5293. Intervertebral Disc Syndrome. The intervertebral disc syndrome involves a herniation of the nucleus pulposus with impingement on the nerve root resulting in irritation and a radicular distribution of pain.

a. In view of the fact that 40percent - 50 percent of the population have herniated discs which are asymptomatic, finding a herniated disk on MRI in a Service member with back pain does not necessarily imply the herniated disk is the primary cause of the pain.

b. Ratings of 40 percent - 60 percent will be predicated upon objective neurological findings supported by laboratory data,

such as EMG, nerve conductive studies, flow and manometric studies for bowel and bladder involvement.

c. The weight attached to each finding shall vary according to the co-presence of other findings.

d. Surgical excision of a disc without evidence of recurrent disc herniation at the same level or a different level precludes the application of the 5293 code.

e. Residual cervical pain with radiculopathy, status post excision of a herniated disc should be rated for the pain (5003) or limitation of motion (5290) and for the radiculopathy under the appropriate 8500 series code.

f. Residual lumbar pain with radiculopathy should be rated as 5295 and the relevant code for neurological impairment.

20. 5295. Lumbosacral Strain

a. Zero percent rating shall be awarded for chronic low back pain of unknown etiology (mechanical low back pain).

b. Demonstrable pain on spinal motion associated with positive radiographic findings shall warrant a 10 percent rating. If paravertebral muscle spasms are also present, a 20percent rating may be awarded. Such paravertebral muscle spasms, however, must be chronic and evident on repeated examinations.

21. 5296. The Skull

a. Areas of loss where bone regeneration has taken place are not ratable. If regeneration has partially closed the defect, only the remaining area of loss is to be rated.

b. Total bone loss from a single area of the skull is not ratable if the defect has been successfully repaired with a prosthetic plate. Residual neurological deficit or cosmetic deformity shall be rated separately if appropriate.

c. The following conversion measurements shall be used in applying VASRD ratings:

(1) Defect of a diagnostic burr hole approximates one square centimeter.

(2) A 25 cent piece (quarter) = 4.6 square centimeters.

(3) A 50 cent piece (half dollar) = 7.35 square centimeter.

d. Diagnostic burr holes and other bony defects are ratable only when contiguous and when there is loss of both inner

and outer tables of bone. The areas are added and the total is rated.

e. When there is total bone loss from multiple areas, such as in trephining, the rating should not be assigned based upon "coin measurement" but on the basis of the aggregate area of loss in terms of square centimeters.

f. Suboccipital skull defects shall not be rated.

22. 5297. Removal of Ribs

a. For removal of ribs, the VASRD requires the complete removal from the vertebral angle to the costo-cartilaginous junction. Removals of a lesser degree are rated as rib resections.

b. The presence of certain conditions precludes the assignment of an additional rating under Code 5297; exceptions are allowed in specific situations. "Notes (1)" and "(2)" under this code in VASRD provide pertinent guidance.

23. 5003-5279. Stress Fractures

a. Since the VASRD has no specific rating schedule for these conditions, rating shall be done, as follows:

(1) If there is radiographic evidence of fracture of the femur or tibia, it should be rated as any other fracture. The Bilateral Factor would apply, if appropriate.

(2) Fracture of the pubic rami confirmed by radiographic findings should be rated under 5003. That is a membranous bone that can be expected to heal quickly. Muscle action of the large thigh adductors is the main aggravating force, not weight bearing.

(3) Fracture of tibial and fibular malleoli are seldom displaced, may not require surgery, and except for offering some comfort, casts are not required. The most appropriate rating would be analogous to 5262, slight.

(4) Stress fracture of the tarsals or metatarsals should be rated under 5279, metatarsalgia.

(5) Tibial plateau and femoral condyle stress fractures are stable unicortical defects which should be rated as analogous to 5259 because of some impairment of knee function. The use of the 5257 would be inappropriate because the lesion is extra-articular and produces pain, not knee instability.

(6) Stress reaction without radiographic evidence of fracture should be rated as periostitis under 5022.

b. Radiographic Evidence. At the time of the original MEB, a Service member may have pain not explained by routine radiographic examination. A bone scan, however, may reveal increased vascularity consistent with stress fracture or stress reaction. After a year, only routine radiographs are necessary to demonstrate that there is or is not evidence of a healed fracture. There is no need for a bone scan. If the Service member originally had a fracture, it will be evident on the radiograph. If the current radiographic is normal, then a fracture did not exist at the time of the MEB. The most likely diagnosis was stress reaction.

c. Service members who develop stress fractures, especially of the femoral neck, during basic training which prevents them from completing basic should be separated with appropriate rating as the injury most likely will recur when the Service member is recycled.

24. 5301-5326. Muscle Injuries

a. Pyramiding must be avoided. For example, separate ratings should not be given for an ankylosed joint and an injured muscle acting on that joint.

b. Ratings for bone and joint impairment should not be combined with ratings for muscle and nerve impairments affecting the same joint.

B. 6000 Series

1. 6000-6092. Diseases of the Eye

a. The adjudication of disabilities of the visual apparatus is difficult. In some cases involving a combination of defects, it may not be possible to arrive at an equitable percentage rating through literal application of the terms of the VASRD. The complexity of those conditions does not permit the construction of a simple schedule that is adequate for the variety of defects and resulting types and degrees of impairment that may occur. Here, the concept of "visual efficiency" may be helpful. Visual efficiency is the product of the interdependent relationship of all the functions of the ocular apparatus, of which the three principal ones are central visual acuity, field of vision, and muscle function. Since the estimation of visual efficiency, as such, is not provided by the VASRD as a means of determining a degree of disability, it is useful only to determine the Service member's real functional handicap so that an equitable rating in terms of the schedule can be recommended.

b. The VASRD provides that the combined disabilities of the same eye are not to exceed the rating for total loss of vision of that eye, unless there is an enucleation or a serious cosmetic defect added to the total loss of vision. Accordingly, where there is a cosmetic defect, even though limited to the eye with

the visual loss, representing a separate and distinct entity, namely, facial disfigurement, a separate rating of 10, 30, or 50 percent is permitted under 7800 to be combined with the rating for visual loss or rating for enucleation.

c. Visual field defects must be reported according to the method prescribed in the VASRD, paragraphs 4.76 and 4.76a. Results of muscle function examinations should be reported in accordance with VASRD, paragraph 4.77. Reference to the AMA Guides to the Evaluation of Permanent Impairment (4th ed.) may assist in computing the extent of impairment.

d. When computerized techniques are used to determine the extent of diplopia, visual fields, or scotomata, the results must be interpreted in relation to the standard VASRD charts to render a rating.

2. 6000-6009. Conditions Involving Structures of the Globe

a. Disabilities resulting from these conditions are rated as follows:

(1) STEP ONE:

(a) Impairment of visual acuity is rated.

(b) Impairment of field of vision is rated.

(c) Active pathology, if present, is rated at 10 percent.

(d) The higher of the ratings in (1) and (2) is combined with (3).

(2) STEP TWO: Pain, rest requirements and/or episodic incapacity are rated from 10 to 100 percent. This rating, when only one eye is involved, is not necessarily limited to the 30 percent rating for total loss of vision of one eye, since pain or rest requirements may be incapacitating to any degree, including total. This rating is assigned the code which covers the basic condition (i.e., Code 6000 through 6009). Analogy to another code is not required. It is an estimate based as nearly as possible upon the actual impairment of social and industrial function which is imposed by the pain experienced, the time lost because of the requirement for rest, the frequency of incapacitating episodes, or any combination thereof. The additional rating of 10 percent for continuance of active pathology should not be combined with this rating.

(3) STEP THREE: The higher of the ratings resulting from Steps One and Two, is awarded.

b. Retained foreign body is rated as active pathology as in Step One, above, if in a critical area or not stabilized. Otherwise, the rating is for residuals under Step Two.

3. 6013. Glaucoma, Simple, Primary, Noncongestive. The minimum rating is applicable if the diagnosis is satisfactorily established, whether or not visual acuity or field of vision has been affected. The rating is for the disease, rather than for functional impairment of an individual organ, and applied whether the disease progresses or not.

4. 6029. Aphakia. Process Involves One or Both Eyes. This condition is usually not unfitting. However, requirements of a particular military occupational skill must be considered in making a fitness determination. If the member is determined unfit, the appropriate rating shall be applied. The condition, if corrected by successful prosthetic implants (pseudophakia), is not considered unfitting or ratable unless the prosthetics are specified as too unstable to withstand duty stress.

5. 6081. Scotoma, Pathological. The rating is 10 percent whether unilateral or bilateral. Other ratings may be combined with the reservation that the rating for one eye may not exceed 30 percent, unless there is enucleation or a serious cosmetic defect. Central scotoma cannot, however, be combined with central visual loss.

6. 6090-6092. Diplopia. The VASRD uses the Goldman Perimeter Chart to describe the location in the field of vision where diplopia occurs. The VASRD, under 6090-6092, converts the location in the field of vision where diplopia occurs to an equivalent visual acuity that then can be used in the final rating. The final rating is achieved by referring to VASRD Table V "Ratings for Central Visual Acuity Impairment". The equivalent visual acuity is substituted for the actual visual acuity of the worse eye (if visual acuity is the same in both eyes, one eye will arbitrarily be considered worse), and plotted against the actual visual acuity of the better eye. The intersecting box provides the percentage rating and the VASRD code.

7. 6309. Rheumatic Fever. When a member is determined to be unfit because of recurrence of disease, the member may be rated at zero percent (see VASRD paragraph 4.31) if there is no residual functional impairment. If residual functional impairment is diagnosed, the member shall be rated accordingly under the proper code.

8. 6350. Lupus Erythematosus, Systemic. Connective-tissue diseases, such as vasculitis, collagen disease, immune complex disease, and other disseminated diseases, not elsewhere covered, are to be rated under that code.

9. 6351. Human Immunodeficiency Virus Infection (HIV) and Acquired Immune Deficiency Syndrome

a. That is the only code used in rating HIV or AIDS.

b. The rating criteria shall be according to the VASRD. The Service member must be determined to be unfit because of that condition before rating. Seropositivity alone is not unfitting.

10. 6354. Chronic Fatigue Syndrome

a. These cases must meet the definition put forth by the National Institutes of Health (NIH Publication No. 92-484). Both major criteria and eight or more of the minor criteria must be met. "Incapacitation" means that the Service member requires bed rest and treatment by a physician.

b. An active duty Service member referred to the respective service DES (disability evaluation system) for Chronic Fatigue Syndrome must have been thoroughly evaluated. The referring MEB shall include a psychiatric evaluation, unit commander assessment, report of observation in a hospital setting, other observer (peers, et. al.) accounts, and interpretation of the results of (at least) the following laboratory tests: blood tests, including CBC; Differential; WBC; ESR; liver function tests; albumin; globin; calcium; phosphate; electrolytes; glucose; BUN; greatinine; thyroid studies, and urinalysis.

c. The fatigue symptoms may be part of the underlying psychiatric disorder. In such cases, the psychiatric disorder rather than Chronic Fatigue Syndrome should be assessed as the potentially unfitting condition. If the Service member is rated separately for Chronic Fatigue Syndrome and the psychiatric disorder, pyramiding would result. However, if the Service member has a psychiatric disorder that is clearly separate from a coexisting Chronic Fatigue Syndrome that is validly based on NIH diagnostic criteria, both conditions should be assessed and rated as to impact on fitness.

11. 6519. Aphonia, Organic. Impairment of ability to speak may be ratable under more than one code, depending on the cause and severity of the impairment. In such instances, the highest applicable rating is awarded. This Instruction does not apply to speech impairment due to loss of whole or part of tongue that is rated under Code 7202.

12. 6600-6630. Disease of the Trachea and Bronchi. Unless contra- indicated, pulmonary function tests, performed both with and without medication, must confirm the clinical diagnosis and severity (See Table 2). If the Service member's condition is subject to significant variation over time, a single clinical and pulmonary function evaluation may not be adequate. Response to therapy is to be considered in all cases. The following pulmonary function test values serve as guidelines in determining ratings (See Table 2).

13. 6701-6704; 6730-6732. Active Tuberculosis. Active tuberculosis shall be rated under code 6730. All periods of time specified in the VASRD for the management of tuberculosis, active or inactive, apply only to the VA and do not apply to the military. Treatment and clinical response shall serve as the criteria for disposition. Rating for residuals shall be based on functional impairment.

14. 6721-6724; 6731. Inactive Pulmonary Tuberculosis

a. Determining Inactivity. Pulmonary tuberculosis is considered to be inactive when:

(1) There are no symptoms of tuberculous origin. Serial roentgenograms show stability or very slow shrinkage of the tuberculous lesion. There is no evidence of cavitation. Sputum or gastric washings show negative on culture or guinea pig inoculation. Those conditions shall have existed for at least 6 months.

(2) Established by evaluation. That is usually, but not always, at the time the patient is declared to have received the maximum benefits of hospitalization.

(3) Six months have passed since surgical excision of an active lesion during which time there shall have been no evidence of tuberculous activity in any body system.

b. Chemotherapy. Treatment by medication is frequently continued beyond the date when the disease becomes inactive according to the above criteria. The ending date of such treatment does not define the beginning of the inactive status.

c. Rating Residuals. A rating of 100 percent for 1 year after the date of attaining inactivity shall not be used. After the condition becomes inactive, residuals (e.g., impairment of pulmonary function, surgical removal or resection of a part) should be rated under the appropriate VA Code, subject to the limitations contained in paragraphs 4.96a and b of the VASRD.

15. 6803-6806, 6808. Mycotic Pulmonary Infections. Active disease is rated by analogy to code 6821.

16. 6807. Aspergilloses of Lung. That code refers only to invasive aspergillosis or to aspergilloma. Active or recurrent allergic aspergillosis is rated by analogy to code 6602 (asthma) raised to next higher level (e.g., "mild" active aspergillosis would be rated as "moderate" asthma). Permanent residuals of allergic aspergillosis are rated analogous to code 6802.

17. 6810. Pleurisy, Serofibrinious. Significant ventilatory impairment is rated as analogous to code 6811.

18. 6814. Pneumothorax. The "100 percent 6 months" rating should not be applied. A known underlying condition may be rated.

If there is none, rating may be analogy to emphysema (code 6603) or pneumoconiosis (code 6802).

19. 6815. Pneumonectomy. Pneumonectomy is rated at 60 percent regardless of number of ribs removed. If, at a later date, thoracoplasty becomes necessary for obliteration of space within the thorax, the rating for pneumonectomy shall be combined with a rating removal of the ribs. Note (2), which follows code 5297 in the VASRD, provides rating guidance for a case of that type.

20. 6816. Lobectomy. An entire lobe other than the right middle lobe must be removed for the defect to be ratable. Excision of the right middle lobe, segment resection, or lingulectomies are not ratable. Ratings are based on total body impairment.

21. 6847. Sleep Apnea Syndromes. The VASRD lists four percentage rating options: 0%, 30%, 50%, and 100% under this code, corresponding to assessed levels of disability relative to civilian earning capacity due to Sleep Apnea. The following interpretation will apply:

Total industrial impairment	100%
Considerable industrial impairment	50%
Definite industrial impairment	30%
Mild industrial impairment	0%

C. 7000 Series Codes

1. 7000 Series. Cardiovascular Disease. (Tables 3 and 3a provide guidance for rating cardiac functional status.)

a. Pyramiding Must be Avoided. Only one rating should be given for all manifestations of cardiovascular or renal disease when, according to accepted medical principles, the conditions have the same origin or cause. For example, hypertension and end organ nephropathy due to arteriosclerosis are related etiologically and may be regarded as one clinical entity. The disability should be rated under the code representing the predominant signs and symptoms. In some cases, the related manifestations in another body system will be so severe as to increase the Service member's overall impairment to the point that the next higher percentage under the selected code shalll be justified. The note in the VASRD under code 7507 is pertinent.

b. Criteria for Assigning Ratings Under These Codes are:

(1) The 100percent rating. When more than sedentary employment is precluded. New York Heart Association Functional Therapeutic Class IV (NYHA FTC IV).

(2) The 60 percent rating. When more than light manual labor is precluded as indicated by a NYHA FTC III heart or

by congestive heart failure as established by a left ventricular ejection fraction reading in the low 20's.

(3) The 30percent rating. When more than ordinary manual labor is prevented, for instance, by NYHA FTC IIb heart.

c. Types of employment referred to, above, and used for rating purposes are:

(1) Sedentary Employment. Work that is not time dependent.

(2) Light Manual Labor. "Bench work" equivalents.

(3) Ordinary Manual Labor. Leg, back, and arm effort; time dependent.

(4) Strenuous Labor. Repetitive and rapid combined arm, leg and trunk effort.

d. Valvular Heart Disease. Valvular heart disease not of arteriosclerotic or hypertensive origin should be rated as rheumatic heart disease, code 7000 if the predominant symptoms are due to valvular pathology.

e. Rheumatic Heart Disease

(1) A determination of existed prior to service for rheumatic heart disease may be justified even though its presence was not previously recorded. Such a determination shall depend upon the medical history and findings in the light of accepted medical principles. A stenotic valvular lesion, discovered early in military service, is an example.

(2) A "definitely" enlarged heart is one in which there is positive evidence of enlargement beyond the "doubtful" or "borderline" enlargement that is sometimes reported when the presence of enlargement is uncertain. Voltage criteria alone are not acceptable as electrocardiographic evidence of definite enlargement. Enlargement of the heart shall be determined by objective evidence using appropriate measures other the electrocardiogram.

(3) The 100 percent rating for active rheumatic heart disease for 6 months is not applicable.

2. 7005-7017. Disease of the Coronary Arteries, Surgical Procedures, and Trauma

a. For Service members on active duty, to include those active duty for less than 31 days, myocardial infarction incurred during such periods shall be presumed "aggravated" by performing such duty. This presumption may be overcome when it can be shown by a preponderance of evidence that the condition was not aggravated by military service.

b. Coronary bypass surgery, valve prosthesis, or other cardiac surgery shall be rated on the extent of residual functional impairment when the condition is stable. If stability cannot be established, a period of TDRL should be considered.

3. 7015-7017; 7110. Surgical Procedures Associated with AV Block, Heart Valve Replacement, Aneurysms. Convalescent ratings and ratings for specified periods of time following surgery do not apply. Ratings are based on the degree of functional impairment. However, maximum ratings do apply.

4. 7100. Arteriosclerosis, general. The 20 percent rating under that code is rarely appropriate. It is preferable to rate impairment of the body system most involved by the disease.

5. 7114-7117. Peripheral Vascular Diseases

a. The symptoms and signs of these conditions should be considered as manifestations of a systemic disease entity, wherein bilateral involvement of extremities is natural and expected. They are distinct from local mechanisms affecting peripheral circulation (for example, varicose veins or phlebitis) in which bilateral involvement is more nearly equivalent to coincidental duplication of the disease, rather than its direct extension.

b. When manifestations are limited to the extremities, the percentage of disability is based on the most severely affected extremity unless each of the two or more extremities separately meets the requirements for valuation in excess of 20 percent. In the latter case, 10 percent shall be added to (not combined with) the valuation for the more severely affected extremity, except where the disease has resulted in amputation. When both upper and lower extremities are involved, the above rating procedures are first applied to the upper extremities, then to the lower extremities. Ratings shall be combined if each group has a total rating in excess of 20 percent.

c. The bilateral factor applies in all cases of an amputation of one extremity with any compensable degree of disability of the other extremity.

d. A rating of 20 percent or less for a peripheral vascular disease should not be combined with any other peripheral vascular disease rating.

e. Peripheral vascular disease ratings for codes 7114 through 7117 are listed in table 4.

6. 7120 (7199-7120). Hypercoagulable states requiring chronic anticoagulation

a. A minimum rating of 30 percent is given if there have been episodes of thrombophlebitis or emboli in the past year.

b. A zero percent rating is given if there have been no episodes of thrombophlebitis or embolus in the past year.

c. Higher ratings are based on residuals to emboli or thrombophlebitis.

7. 7305. Ulcer, Duodenal. Medical and surgical management have been increasingly effective. Cases refractory to accepted medical therapy may be determined unfit for continued active duty.

8. 7307. Gastritis, Hypertrophic. That diagnosis must be made by endoscopy. It should not be rated separately, however, if other conditions are present that produce a common impairment. A single valuation shall be assigned under the diagnostic code that reflects the predominant disability with elevation to the next higher rating if the severity of the overall disability warrants.

9. 7308. Postgastrectomy Syndrome. In evaluating and rating, care must be taken to differentiate between nondisabling symptoms or minor discomfort which sometimes result from overindulgence, such as that experienced from overeating by a person without a gastrectomy, and discomfort symptomatic of a true postgastrectomy syndrome. Circulatory or comparable symptoms, even though mild or intermittent, such as a need for rest after meals, are indicative of impairment that may be a basis for rating.

10. 7328-7329. Intestinal Resections. When portions of both large and small intestines have been removed, the rating should be done using the code that is most representative of the clinical manifestations.

11. 7332-7336. Ano-Rectal Conditions. Pilonidal cyst or sinus is primarily a disorder of ectoderm and shall be rated as a skin condition. However, when an active process is present the rating is by analogy to Code 5000.

12. 7338. Hernia, Inguinal. If correctable and there are not contra-indications to surgery, hernia is not ratable even if surgery if refused.

13. 7345. Hepatitis, Infectious

a. Acute infectious hepatitis will usually resolve without residual impairment. Liver function tests should return to normal.

b. Chronic persistent hepatitis is a condition with minimally disturbed histology and liver function tests. There is no persistent disability or progression, and both time and supporting evidence confirm that. Rating for residuals is seldom justified. Placement on the TDRL may be proper when the clinical and laboratory course (particularly in the presence of persistent

antigenemia) indicates a need for continued observation to rule out chronic active hepatitis.

c. Chronic active hepatitis is a frequently progressive condition that may or may not be associated with a demonstrable antigen. Since the course of the disease is often difficult to predict, placement on the TDRL may be proper before permanent disposition is made.

14. 7347. Pancreatitis. If diabetes is present, the predominant disease should be rated, with consideration given to the other, under a single code, to avoid pyramiding.

15. 7500-7542. The Genitourinary System

a. The VASRD has published a new rating scheme for disabilities related to the genitourinary system based on renal or voiding dysfunctions, infections, or a combination of these. The major areas of rating are as follows:

(1) Renal dysfunction

(2) Voiding dysfunction

(a) Urinary frequency

(b) Obstructed voiding

(3) Urinary tract infection

b. 7500-7531. The Genitourinary System. Sterility and impotence are not ratable entities. Anatomical loss of procreative organs shall not be rated.

c. 7500-7509. Upper urinary tract. In assessing impairment of the upper urinary tract, the endogenous creatinine clearance tests serve as guidelines for evaluating renal function. Normal creatinine clearance is 80-139 milliliters (ml)/minute in men and 80-125 ml/minute in women. (See Table 5).

d. 7512. Total Incontinence. Incontinence may be rated as bladder fistula, 100 percent, when use of an appliance is unsatisfactory or not feasible.

e. 7526. Prostate Resection. In order to be ratable, there must be symptoms and objective evidence of impairment.

f. 7528. New growths, Malignant, Any Specified Part of Genitourinary System. Some malignant tumors of the genitourinary tract are subject to cure, even if widespread metastases have taken place. Completion of treatment and follow-up on active duty are desirable. If adverse reaction to treatment or persistent evidence of tumor activity interfere with duty, TDRL may be

considered. In those instances when specific tumors are refractory to all treatment, final disposition should be made.

g. 7542. Neurogenic Bladder. The number of required catheterizations or number of changes of absorbent pads per day should be listed to ascertain the functional impairment.

16. 7600-7627. Gynecological Conditions

a. The VASRD has rating criteria for unfitting gynecological conditions that include endometriosis and removal of the mammary gland(s) or segments of the mammary gland.

b. 7617, 7618, 7619. Procreative Organs. Loss of procreative organs is not ratable. Only significant disqualifying residuals should be rated.

c. 7626-7627. Mammary Gland Removal. Not all Service members who have had mastectomies for malignancy are unfit. Unfitness is based on residual impairment of the arm or chest wall or effects of radiation or other treatment. The 100 percent rating in the VASRD does not apply in cases in which the Service member does not have evidence of metastasis.

17. 7703. Leukemia. Leukemia requiring the use of chemotherapeutic agents is rated analogous to leukemia requiring irradiation or transfusion. Although some prolonged remissions and "cures" are being achieved with acute leukemia, temporary retirement should be considered in most cases at a maximum rating. Service members with chronic leukemia who require treatment are often fit for prolonged periods of time with few profile restrictions. Such cases must be individually judged on their merits. The principles noted below under 7709, paragraph (2), should be considered in leukemia cases.

18. 7705-7706. Purpura Hemorrhagica; Splenectomy. Only residuals, if any, of the basic condition leading to the splenectomy should be rated.

19. 7709. Lymphogranulomatosis (Hodgkin's Disease)

a. Clinical staging serves as a general guide for treatment, rating, and disposition of Hodgkin's Disease. Table 6 can be used with the understanding that many advances in treatment that may permit exceptions are taking place.

b. Prolonged remissions and cures, even with salvage treatment, are becoming more commonplace. Regardless of the pretreatment stage of the disease, retention on active duty during treatment, or return to active duty after treatment on the TDRL may be possible. Intensive treatment, however, may be extremely traumatic. Degradation of both physical and mental functions may be disabling for varying periods of time. Final

disposition must be individualized according to both subjective and objective residuals.

20. 7714. Sickle Cell Anemia. The VASRD rates all the manifestations of sickle cell disease and its variants. Individuals with the more severe hemoglobinopathies are not acceptable for entry into the Military Services. Policies concerning line of duty and Service aggravation apply.

21. 7716. Aplastic Anemia. That is a new ratable condition. A Service member scheduled for transplantation shall be rated after the transplant.

22. 7801-7802. Scars, Burns. When calculating burn areas, Plate IV, Table 7 and the following measurements may be of assistance:

Average 70kg (150 lbs) male body surface = 1.7m2
2636 in2 = 18.3 ft2
1 meter = 39.375 inches
1 meter2 = 1550.4 in2

23. 7913. Diabetes Mellitus

a. The format published by the National Diabetes Group shall serve as the basis for classifying diabetes mellitus (DM). The severity of each case should be individualized taking into consideration the expected natural course of the disease variants. Insulin dosage is not a good indicator of severity and is only one factor to consider in the overall evaluation of the disease. Response to specific therapy, diet, activity, compliance, and time are all important. With adequate compliance, many diabetics are fit with minimum restrictions. That is particularly true of type II DM (noninsulin dependent), even though insulin is prescribed for optimum control. Young adults with type I DM (insulin dependent) are not a good risk for retention.

b. If unfitness derives, in part, from documented non-compliance with prescribed treatment, including diet and weight control, the assigned rating should not be higher than the disease would warrant if under prescribed treatment.

c. DM controlled by diet and oral medication, without a need for daily insulin, and that does not impair health or vigor, or cause significant limitation of activity, is considered to be mild, if unfitting.

d. Ratings must reflect the severity of the DM, as such. Undue importance should not be given to early or questionable complications. That is particularly true in considering ratings of 60 percent or above. In most instances, a lower rating should be given. Complications such as vascular insufficiency, visual defects, pruritis, and neuropathies should be rated separately. The presence of early or questionable

complications in otherwise less than severe DM does not automatically warrant a higher rating.

D. 8000 Series Codes

1. 8000-8412. Organic Disease of the Central Nervous System

a. Careful correlation of the footnote under 8046 with the italicized introduction to 8000-8046 should enable Boards to select the proper rating approach. In some of those conditions, the minimum rating may be awarded on the basis of the diagnosis alone, whether or not there are residuals. In others, the minimum rating may be awarded only if there are residuals. If such cases have neither residuals capable of objective verification nor subjective residuals which are credible, consistent with the disease, and are not more likely attributable to other disease, the condition should be ratable at zero percent, if the Service member is unfit.

b. 8007-8009. Brain Vessels. The six-month convalescent rating does not apply. In many of these cases, the danger of disastrous recurrences justifies a rating (of residuals) sufficiently liberal to provide temporary retirement and subsequent re-evaluation.

c. 8017-8018, 8023-8025. Degenerative Disorders of the Central Nervous System. Combined ratings may be assigned under those codes with the bilateral factor added.

d. 8100. Migraine. "Prostrating" means that the Service member must stop what he or she is doing and seek medical attention. The number of prostrating attacks per time period (day, week, month) should be recorded by a neurologist for diagnostic confirmation. Estimation of the social and industrial impairment due to migranious attacks should be made.

e. 8108. Narcolepsy. The VASRD defers the determination of disability ratings to code 8911 (epilepsy, petit mal). The latter code lists five percentage rating options for minor seizures: 10%, 20%, 40%, 60%, and 80% corresponding to assessed levels of disability relative to civilian earning capacity due to subject condition. The following interpretation will apply:

Profound industrial impairment	80%
Severe industrial impairment	60%
Considerable industrial impairment	40%
Definite industrial impairment	20%
Mild industrial impairment	10%

f. 8205-8412. Diseases of the Cranial Nerves. There is provision for combined ratings under these codes when there is bilateral involvement, but without the addition of the bilateral factor.

2. 8510-8730. Disease of the Peripheral Nerves

a. Cases that are rated based on residuals should be adjudicated on the basis of impairment of function rather than on anatomical diagnosis. For example, a complete paralysis of the circumflex nerve of the major extremity carries a 50 percent rating under 8518. In many cases, however, abduction of the arm when the circumflex nerve is paralyzed is possible because other muscles take over the function of the paralyzed muscles. To warrant the 50 percent rating, the Service member's residual loss of function must actually include all the defects listed under 8518. When other muscles have taken over the function of the circumflex-innervated deltoid, the residual loss of function is properly ratable under 5201, "limitation of arm motion", or 5303, "muscle injury, Group III", whichever better reflects the predominant impairment. Careful documentation of evaluations are required before assigning a rating for paralysis that would equal that for amputation of the innervated area. For example, cases of "paralysis of the common peroneal nerve with foot drop", 8521, should be rated in terms of loss of function. "Amputation below the knee", 5165, is ratable at 40 percent. In order to warrant a similar rating for peroneal palsies, there must be sufficiently severe symptoms, such as trophic and circulatory changes and other concomitants, to make the functional impairment reasonably equivalent to loss of foot.

b. Service members with paralysis of an extremity or hemiparesis shall be rated according to the Table of Analogous Ratings. Codes are as follows:

(1) 8599 - 8513 - Paralysis of upper extremity

(2) 8599 - 8520 - 8526 - Paralysis of lower extremity

c. 8599. Scalenus Anticus Syndrome. That syndrome is rated by analogy with the lower radicular group (8512), or less commonly, with either erythromelalgia (7119) or Raynaud's Disease (7117), depending upon predominant symptoms and overall functional impairment.

3. 8910-8914. Epilepsies

a. Service member must be evaluated and the diagnosis made by a neurologist.

b. The number of seizures each time frame (day, week, and month) must be recorded.

c. Attacks following omission of prescribed medication or the ingestion of alcoholic beverages are not indicative of the controllability of the disease and are not relevant to the determination of seizure frequency for rating purposes.

d. Estimation of the social and industrial impairment due to the seizure activity should be made.

e. Seizures that occur during sleep ("nocturnal seizure") are not relevant to the determination of seizure frequency unless they can be shown to significantly impair industrial adaptability.

E. 9000 Series Codes

1. 9200-9511. Mental Disorders

a. Functional Impairment. Loss of function is the principal criterion for establishing the level of impairment resulting from mental illness. Loss of function is reflected in impaired social and industrial adaptability. Psychoses specifically include disorders manifesting disturbances of perception, thinking, emotional control, and behavior, severe enough to hinder economic adjustment, that is, hinder the Service member's capacity to perform military duties or to earn a living. Even psychosis, however, may resolve such that the impact on economic adjustment is minimal to none.

(1) In rating impairment of social and industrial capability, if any, a comparison must be made between pre- and post-illness adjustment. All pertinent information provided by the MEB and TDRL interim examination done by the examining physicians and other competent medical authorities should be reviewed before arriving at a final determination. Inconsistencies between the clinical data (history, mental status, hospital course, and present condition) and the diagnosed psychiatric condition, or between data provided by different physicians must be resolved before a final rating decision. Action taken to resolve these difference should be documented in the proceedings.

(2) Assessing the degree of permanent impairment resulting from a psychotic process is often difficult during the weeks immediately following an acute episode. Sometimes a Service member's period of intensive in-hospital treatment has not been completed at the time of the initial MEB. With the passage of time, the clinical picture often becomes stable. The degree of permanent impairment may then be estimated more accurately.

b. Social impairment. Information that relates to social impairment includes, but is not limited to, the following:

(1) Living arrangements (by oneself, with parents and siblings, or with wife and children).

(2) Marital status (single, married, separated, or divorced, and the type of relationship (harmony or strife)).

(3) Leisure activity (sports, hobbies, TV, reading, sleeping).

(4) Acquaintances (male, female, both sexes, many, few).

(5) Substance use or abuse (alcohol and/or illicit drugs).

(6) Police record.

c. Industrial Impairment. Information that relates to industrial impairment includes, but is not limited to, the following:

(1) Job stability (unemployed, part-time work, full-time job, quit, fired, or promoted).

(2) Type of job (menial, responsible, OJT, technical, for a relative, or for a private employer).

(3) Schooling (grade, technical, academic, high school, college, or postgraduate).

d. Additional Factors. Other factors that bear on social and industrial adaptability include, but are not limited to, the following:

(1) Mental Competency. The MEB should include a statement as to whether the Service member is competent to handle his or her financial affairs, and to participate in Board proceedings.

(2) Level of Supervision. There are several levels of supervision. The most disabling is constant hospitalization. Constant supervision at home or intermittent and repeated hospitalizations are disabling factors to be considered. Being placed in one's own custody suggests that a lower level of supervision, if any, is required.

(3) Contact with Reality. Certain Service members have lost all contact with reality and cannot tell fact from fantasy. Dreams, imaginations, delusions, and hallucinations are just as real to certain Service member as actual events. The quality of loss of contact with reality as well as quantity of time that the Service member is not in contact with reality are factors to be considered.

(4) Potential for Harm. At times, individuals suffering from mental disorders may be dangerous to themselves or to others. They may be homicidal, suicidal, or violently destructive to property. Their judgment may be so impaired that they could jeopardize or destroy a family, business, or themselves, financially, socially, and legally.

(5) The degree of industrial and industrially related social impairment is influenced by the number and intensity of signs or symptoms of mental disorders. Those signs or symptoms may be overtly apparent or they may be subtle and apparent only to skilled examiners. Their significance must be carefully evaluated. A partial list of the more common signs or symptoms include autism, ambivalence, inappropriate affect, dissociative thinking, bizarre behavior, delusions, hallucinations, pronounced anxiety, hyperactivity, depression, disorientation, emotional lability, memory defects, unfounded somatic complaints, phobias, compulsions, lack of insight, and poor judgment.

(6) Medication or Psychotherapy. The type of (potent or mild), the amount (large or small doses) and the route of administrations of medication as well as the frequency (daily, weekly, or as needed) should be considered. The frequency of psychotherapy and by whom administered (psychiatrist, psychologist, social worker, nurse) also should be considered. The fact that a Service member is receiving medication and/or psychotherapy does not automatically equate with a certain level of disability.

e. VASRD Classification. The VASRD uses specific terms to classify the level of social and industrial impairment. Those are further characterized below for ratings under 9201 through 9511.

(1) Total at 100 percent.

(a) Usually mentally incompetent to handle financial affairs and to participate in PEB proceedings.

(b) Usually hospitalized; rarely in care of next of kin or guardian.

(c) Actively psychotic, and often totally out of con-tact with reality.

(d) Requires constant supervision and care.

(e) Significant potential to be harmful to self or others.

(f) Employability limited to sheltered supervised settings.

(g) Incapable of any social adjustment.

(2) Severe at 70 percent.

(a) Usually financially mentally competent and capable of cooperating in PEB proceedings but occasionally may be incompetent.

(b) Usually hospitalized, but often in care of next of kin or guardian.

(c) Actively psychotic, but may have intermittent contact with reality.

(d) Requires supervision approximately 50 percent or more of the time.

(e) Some potential to be harmful to self or others.

(f) Unemployable

(g) Evidence of minimal social adjustment.

(3) Considerable at 50 percent.

(a) Nearly always mentally competent to handle financial affairs and to participate in PEB proceedings.

(b) Overtly displays some signs or symptoms of mental illness such as: autism, ambivalence, inappropriate affect, dissociative thinking, delusions, hallucinations, hyperactivity, depression, lack of insight, poor judgment, bizarre behavior, disorientation, emotional lability, memory defects, unfounded somatic complaints, phobias, compulsions, decreasing IQ, and personality changes.

(c) Requires constant medications or psychotherapy.

(d) Suffers extreme job instability (not due to substance abuse, economic conditions, personality disorders, etc.

(e) Suffers significant industrially related social maladjustment (not due to substance abuse, economic conditions, personality disorders, etc.

(f) May demonstrate a significant requirement for hospitalization.

(4) Definite at 30 percent.

(a) Does not demonstrate a significant requirement for hospitalization.

(b) Displays some signs or symptoms of mental illness on examination.

(c) Usually requires medication and/or frequent psychotherapy.

(d) May experience some job instability.

(e) Evidences borderline social adjustment.

(5) Mild at 10 percent

(a) Maintains an adequate job adjustment.

(b) Maintains an adequate social adjustment.

(6) Full remission at zero percent.

(a) Symptom free.

(b) Requires only interval medical supervision.

(c) Has an acceptable work record, if employed.

f. Table 8 has been compiled to assist in the determination of functional impairment. Terminology is consistent with the "Diagnostic and Statistical Manual of Mental Disorders IV." It is viewed as an aid rather than a prescription.

Table 1
Grade Value Table

A Individual Finger Defect	B Rated As	C Grade Value
Amputation through distal phalanx or distal joint (except the thumb) other than negligible tip loss.	Favorable ankylosis (See VASRD, note c following code 5151)	1
Amputation through middle phalanx or distal phalanx of thumb.	Unfavorable ankylosis (See VASRD, note b following code 5151)	2
Amputation though proximal phalanx or proximal inter-phalangeal joint.	Amputation (See VASRD, note a following code 5151)	3
Amputation of entire digit, with amputation or resection of more than one-half of the metacarpal.	Single finger amputation with metacarpal resection (See VASRD, codes 5152-5156)	4

Table 2
Pulmonary function test values[1]

(FEV-1) Forced Expiratory Volume (FEV-1) (Percentage of predicted)	Rating
Chronic Obstructive Pulmonary Disease (Before Bronchodilators)	
50 or less	Severe
55-65	Moderate, moderately severe
65-70	Mild
70 or better	Normal

Vital Capacity (VC) (Percentage of predicted)	Rating
Chronic Restrictive Pulmonary Disease	
50 or less	Severe
55-65	Moderate, moderately severe
65-80	Mild
80 or better	Normal

[1] The AMA "Guides to the Evaluation of Permanent Impairment," while differing slightly from the above values, is otherwise helpful in interpreting clinical and functional values. There are no FEV-1 Percentage or VC Percentage between 51 and 54.

Table 3
Methods of Assessing Cardiovascular Disability

New York Heart Association Functional Class Classification	Canadian Cardiovascular Society Functional Classification	Specific Activity Scale (Goldstein et al: Circulation 64:1227; 1981 and Science of American Medicine I: 15-16)	New York Heart Association Functional Class Classification (Revised)
I. Patient with cardiac disease, but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, dyspea, or anginal pain.	Ordinary physical activity, such as walking or climbing, does not cause angina. Angina with rapid or strenuous or prolonged exertion at work or recreation.	Patients can perform to completion any activity requiring 7 metabolic equivalent: e.g., can carry 24 lbs up eight steps, carry objects that weigh 80 lbs, do outdoor work (shovel snow or spade soil), do recreational activities (skiing, basketball, squash, handball , jog and walk 5 MPH). **(See table 3A, Approximate Metabolic Cost of Activities)**	Cardiac status uncompromised.
II. Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, and anginal pain.	Slight limitation of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, in wind, or under emotional stress, or during the few hours after awakening. Walking more than two blocks and climbing more than one flight of stairs at normal pace under normal conditions.	Patient can perform completion of any activity requiring $\geq$ 5 metabolic equivalents, but cannot and does not perform to completion activities requiring metabolic equivalents: e.g., have sexual intercourse without stopping, garden, rake, weed, roller skate, dance, fox trot, walk at 4 MPH on level ground. **(See table 3A, Approximate Metabolic Cost of Activities).**	Cardiac status slightly compromised
III. Patient with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dysnea, or anginal pain.	Marked limitation of ordinary physical activity. Walking one to two blocks on the level and climbing more than one flight in normal conditions.	Patients can perform to completion any activity requiring $\geq$ 2 metabolic equivalents but cannot and does not perform to completion any activities requiring $\geq$ 5 metabolic equivalents: e.g., shower without stopping, strip and make bed, clean windows, walk 2.5 MPH, bowl, golf, dress without stopping **(See table 3A, Approximate Metabolic Cost of Activities)**	Cardiac status moderately compromised

Table 3
Methods of Assessing Cardiovascular Disability, continued

New York Heart Association Functional Class Classification	Canadian Cardiovascular Society Functional Classification	Specific Activity Scale (Goldstein et al: Circulation 64:1227; 1981 and Science of American Medicine I: 15-16)	New York Heart Association Functional Class Classification (Revised)
IV. Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiently or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.	Inability to carry on any physical activity without discomfort -- anginal syndrome may be present at rest.	Patient cannot and does not perform to completion activities requiring ≤ 2 metabolic equivalents. Cannot carry out activities listed above (specific activity scale, Class III). **(See Table 3A, Approximate Metabolic Cost of Activities)**	Severely compromised

New York Heart Association Therapeutic Classification

Therapeutic Classification	Revised Classification (Prognosis)
Class A -- Patients with cardiac disease whose physical activity need not be restricted.	Class I - Good
Class B -- Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against severe or competitive physical efforts.	Class II - Good with therapy.
Class C -- Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose strenuous efforts should be discontinued.	Class III - Fair with therapy.
Class D -- Patients with cardiac disease whose ordinary physical activity should be markedly restricted.	Class IV - Guarded despite therapy.
Class E -- Patients with cardiac disease who should be at complete rest, confined to bed or chair.	

Table 3A
Approximate Metabolic Cost of Activities (Source: American Heart Association)

Energy Expenditure	Occupational	Recreational
1.5 - 2 METs [1] 4-7 ml O2/kg/min; 2-2.5 kcal/min (70 kg person)	Desk work Driving an automobile [2] Typing (electric) Electric calculating machine operation.	Standing Walking (strolling 2.6 km or 1 mph) Piloting a plane [2], motorcycling [2] Playing cards [2] Sewing, knitting
2-3 METs 7-11 ml O2/kg/min; 2.5-4 kcal/min (70 kg person)	Auto Repair Radio/TV work Janitorial work Typing (manual) Bartending	Level walking (3.25 km or 2 mph) Level bicycling (8 km or 5 mph) Riding lawn mowers Billiards, bowling Skeet [2], shuffleboard Woodworking (light) Driving a powerboat [2] Golf (using power cart) Canoeing (4 km or 2.5 mph) Horseback (walk) Playing various musical instruments
3-4 METs 11-14 ml O2/kg/min; 4-5 kcal/min (70 kg person)	Brick laying, plastering Pushing a wheelbarrow (45 kg or 100 lb load) Machine assembly Driving a tractor trailer in traffic Welding (moderate load) Cleaning windows	Walking (5 km or 3 mph) Cycling (10 km or 6 mph) Horseshoe pitching Volleyball (6 man, competitive) Golf (pulling bag cart) Archery Sailing (handling small boat) Fly fishing (standing in waders) Horseback (sitting while trotting) Badminton (social doubles) Pushing light power mower Energetically playing various music instruments
4-5 METs 14-18 ml O2/kg/min; 5-6 kcal/min (70 kg person)	Painting Masonry Paperhanging Light carpentry	Walking (5.5 km or 3.5 mph) Cycling (13 km or 8 mph) Table tennis Golf (carrying bag) Dancing (fox trot) Badminton (singles) Tennis (doubles) Raking leaves, hoeing Various calisthenics
5 - 6 METs [1] 18-21 ml O2/kg/min; 6-7 kcal/min (70 kg person)	Digging in garden Shoveling light earth	Walking (6.5 km or 4 mph) Cycling (16 km or 10 mph) Canoeing (6.5 km or 4 mph) Horseback riding (posting while trotting) Stream fishing (walking in light current with waders) Ice or roller skating (15 km or 9 mph)

Table 3A
Approximate Metabolic Cost of Activities, continued (Source: American Heart Association)

Energy Expenditure	Occupational	Recreational
6-7 METs 21-25 ml O2/kg/min; 7-8 kcal/min (70 kg person)	Shoveling 10/min (4.5 kg or 10 lb)	Walking (8 km or 5 mph) Cycling (17.5 km or 11 mph) Badminton (competitive) Tennis (singles) Splitting wood Snow shoveling Hand lawn mowing Square dancing Downhill skiing (light) Ski Touring (4 km or 2.5 mph) (light snow) Water-skiing
7-8 METs 25-28 ml O2/kg/min; 8-10 kcal/min (70 kg person)	Digging ditches Carrying 36.3 kg or 80 lb Sawing hardwood	Jogging (8 km or 5 mph) Cycling (19 km or 12 mph) Horseback riding (gallop) Downhill skiing (vigorous) Basketball Mountain climbing Ice hockey Canoeing (8 km or 5 mph) Touch football Paddleball
8-9 METs 28-32 ml O2/kg/min; 10-11 kcal/min (70 kg person)	Shoveling 10/min (6.4 kg or 14 lb)	Running (9 km or 5.5 mph) Cycling (21 km or 13 mph) Ski Touring (6.5 km or 4 mph) (loose snow) Squash (social) Handball (social) Fencing Basketball (vigorous)
≥ 10 METs ≥ 32 ml O2/kg/min; ≥ 11 kcal/min (70 kg person)	Shoveling 10/min (7.3 kg or 16 lb)	Running: 6 mph = 10 METs 7 mph = 11.5 METs 8 mph = 13.5 METs 9 mph = 15 METs 10 mph = 17 METs Ski Touring (8 km or 5+ mph) Handball (competitive) Squash (competitive)

[1] One MET = energy expenditure at rest equivalent to approximately 3.5 ml O2/kg body weight/minute.
[2] A major excess metabolic increase may occur owing to excitement, anxiety, or impatience in some of these activities. A physician must assess the patient's physiologic reactivity.

Table 4
Peripheral Vascular Disease Rating

Number of Extremities Involved	Rating of Extremities	Combined Rating
One	20	20
	40	40
	60	60
Two (not paired, arm and leg)	20 and 20	20
	40 and 20	40
	40 and 40	60
	60 and 20	60
	60 and 40	80
	60 and 60	80
Two paired (arms and/or legs)	20 and 20	20
	40 and 20	40
	40 and 40[1]	50
	60 and 20	60
	60 and 40[1]	70
	60 and 60[1]	70
Three extremities involved (paired extremities and one other)	20 and 20 and 20	30
	20 and 20 and 40	40
	20 and 20 and 60	60
	40 and 20 and 20	40
	40 and 20 and 40	60
	40 and 20 and 60	80
	40 and 40 and 20	50
	40 and 40 and 40	70
	40 and 40 and 60	80
	60 and 40 and 20	70
	60 and 40 and 40	80
	60 and 40 and 60	90
	60 and 60 and 20	70
	60 and 60 and 40	80
	60 and 60 and 60	90

[1] Bilateral factor applied.

Table 4
Peripheral Vascular Disease Rating, continued

Number of extremities Extremities Involved	Rating of Extremities	Combined Rating
All extremities (both paired extremities)	20 and 20, 20 and 20	20
	40 and 20, 20 and 20	40
	60 and 20, 20 and 20	60
	40 and 40, 20 and 20	50
	40 and 20, 40 and 20	60
	40 and 40, 40 and 20	70
	40 and 40, 40 and 40	80
	60 and 40, 40 and 40	90
	60 and 40, 60 and 40	90
	60 and 60, 40 and 40	90
	60 and 60, 60 and 40	90
	60 and 60, 60 and 60	90

Table 5
Creatinine Clearance and Renal Impairment

Creatinine Clearance	Impairment
Less than 28 ml/minute	Severe (pronounced nephritis)
28-52 ml/minute	Moderate (moderate nephritis)
52-80 ml/minute	Mild (mild nephritis)

Table 6
Hodgkin's Disease

Stage	(Stage A) Rating	(Stage B) Rating	Disposition (if Unfit)[1]
I	30	60	TDRL
II	30	60	TDRL
III	60	- -	TDRL
III	- -	100	PDRL
IV	100	100	PDRL [2]

[1] - Fitness or unfitness is not determined, as a rule, until response to initial treatment has been assessed.
[2] - TDRL may be considered as an exception when there has been a prompt, complete remission during the initial treatment phase.

Table 7 Body Surface Area Measurements

Body Surface	Percent of Body Surface	Area	
		Sq Inches	Sq Feet
Anterior or posterior head	3.5	92	0.64
Anterior or posterior neck	1.0	26	0.18
Anterior or posterior trunk	13.0	343	2.28
Anterior or posterior arm	2.0	53	0.37
Anterior or posterior forearm	1.5	40	0.27
Valar or palmar hand and fingers	1.25	33	0.23
Buttocks	2.5	66	0.46
Genitalia	1.0	26	0.18
Anterior or posterior thigh	4.75	125	0.87
Anterior or posterior calf	3.5	92	0.64
Dorsal foot or sole, including toes	1.75	46	0.32

Table 8 Psychiatric Functional Impairment Guideline Summary

	100 Total	70 Severe	50 Considerable	30 Definite	10 Mild	0 Remission
Competence PEB	Usually incompetent Usually incompetent	Usually competent Occasionally incompetent	Competent Competent	Competent Competent	Competent Competent	Competent Competent
Signs	Actively psychotic; totally out of contact with reality	Actively psychotic; intermittent contact with reality	Overt display of symptoms listed	Display signs/symptoms on exam	Minimal signs on probing	None
Hospitalization	Usually hospitalized Rarely with next of kin	Usually hospitalized Often with next of kin	Intermittent hospitalization	Not required	Not required	Not required
Supervision	Constant supervision/care	Required > 50% of time	Limited to none	Not required	Not required	Not required
Job Stability	Unemployable	Employable. Sheltered workshop	Extreme instability	Moderately unstable	Adequate job adjustment	Stable
Social Adjustment	Incapable of social adjustment	Minimal social adjustment	Significant social mal-adjustment	Borderline	Adequate	Satisfactory
Medication	Assume constant	Assume constant	Requires constant medication	Usually required	May require	No medication
Psychotherapy	Assume constant	Assume constant	Requires frequent psychotherapy	Usually required	May require or may need periodic monitoring of medications	Not required
Harm to self/others	Significant potential	Some potential	Low potential	Low potential	Very low potential	None

MEASUREMENT OF ANKYLOSIS AND JOINT MOTION

Upper Extremities

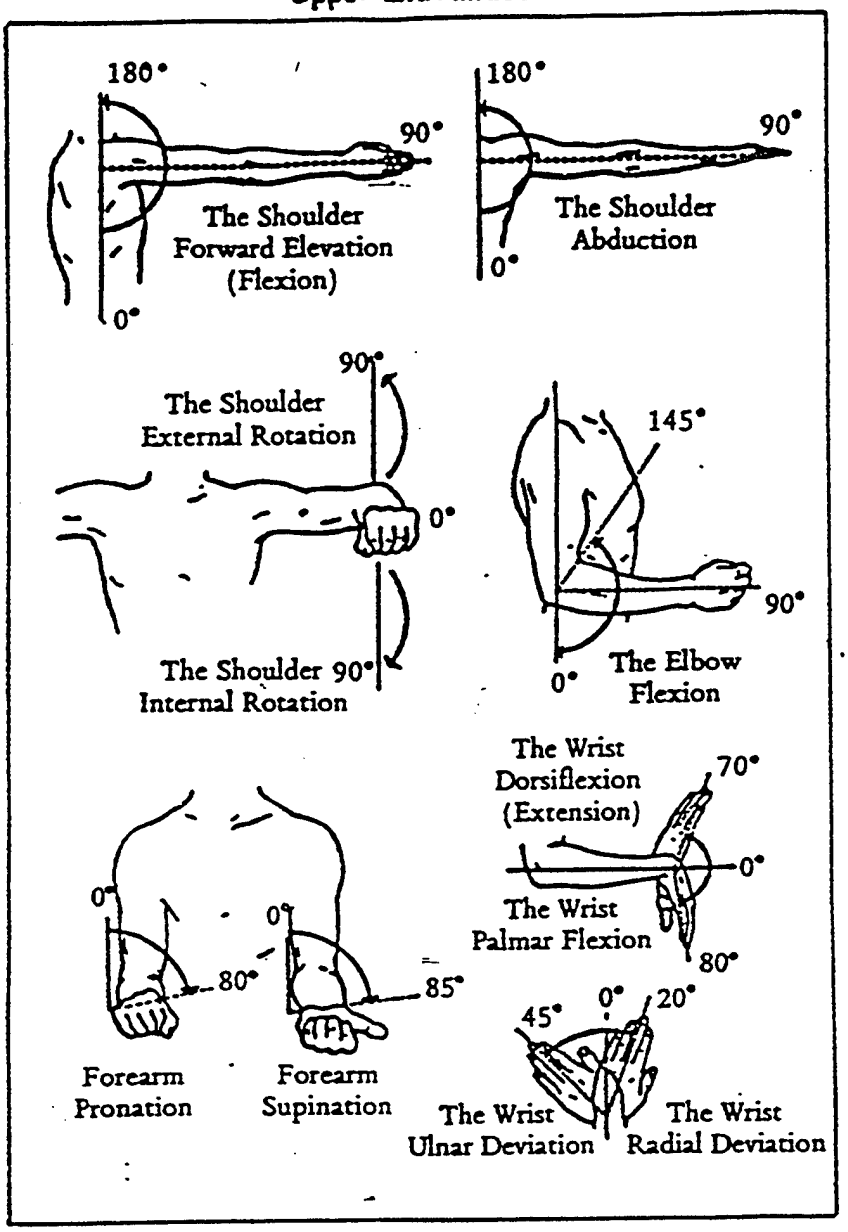


PLATE I

This plate provides a standardized description of ankylosis and joint motion measurement of the upper extremities. The anatomical position is considered as 0° with two major exceptions: (1) in measuring shoulder rotation, the arm is abducted to 90° and the elbow is flexed to 90° so that the forearm reflects the midpoint (0°) between internal and external rotation of the shoulder; and (2) in measuring pronation and supination, with the arm next to the body and the elbow flexed to 90°, the forearm is in mid-position (0°) between pronation and supination when the thumb is uppermost.

Figure 2-1-1 (Plate I)

MEASUREMENT OF ANKYLOSIS AND JOINT MOTION

Lower Extremities

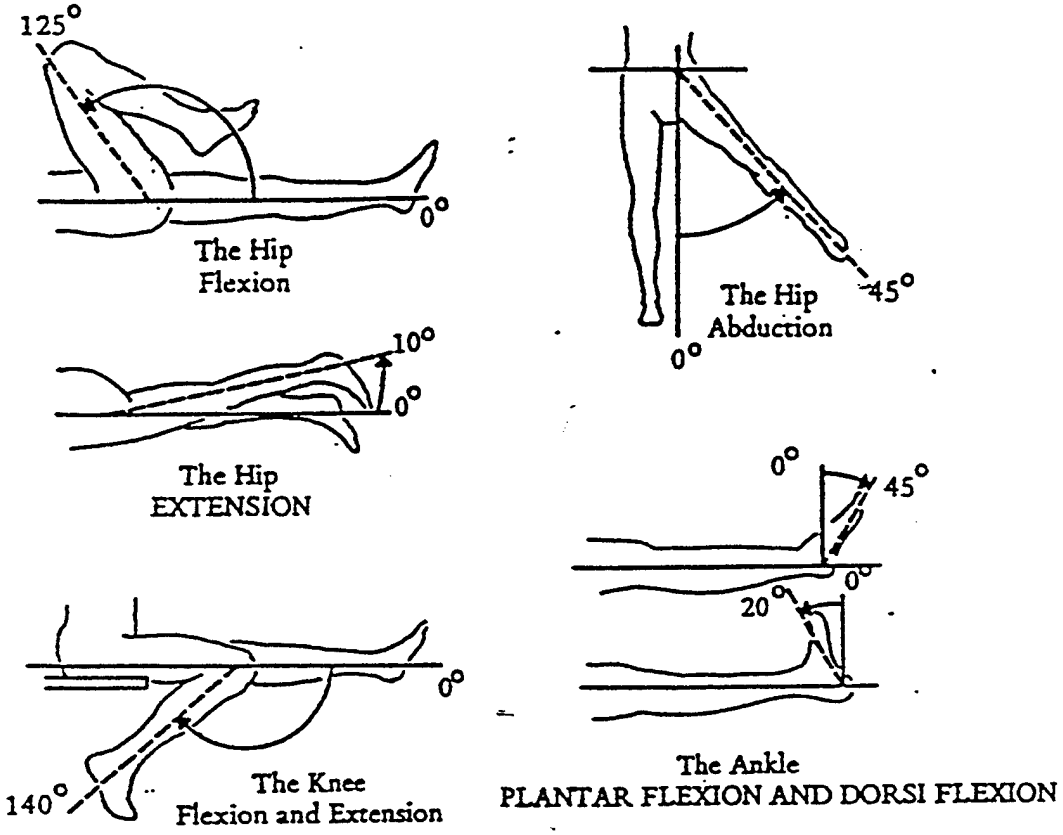
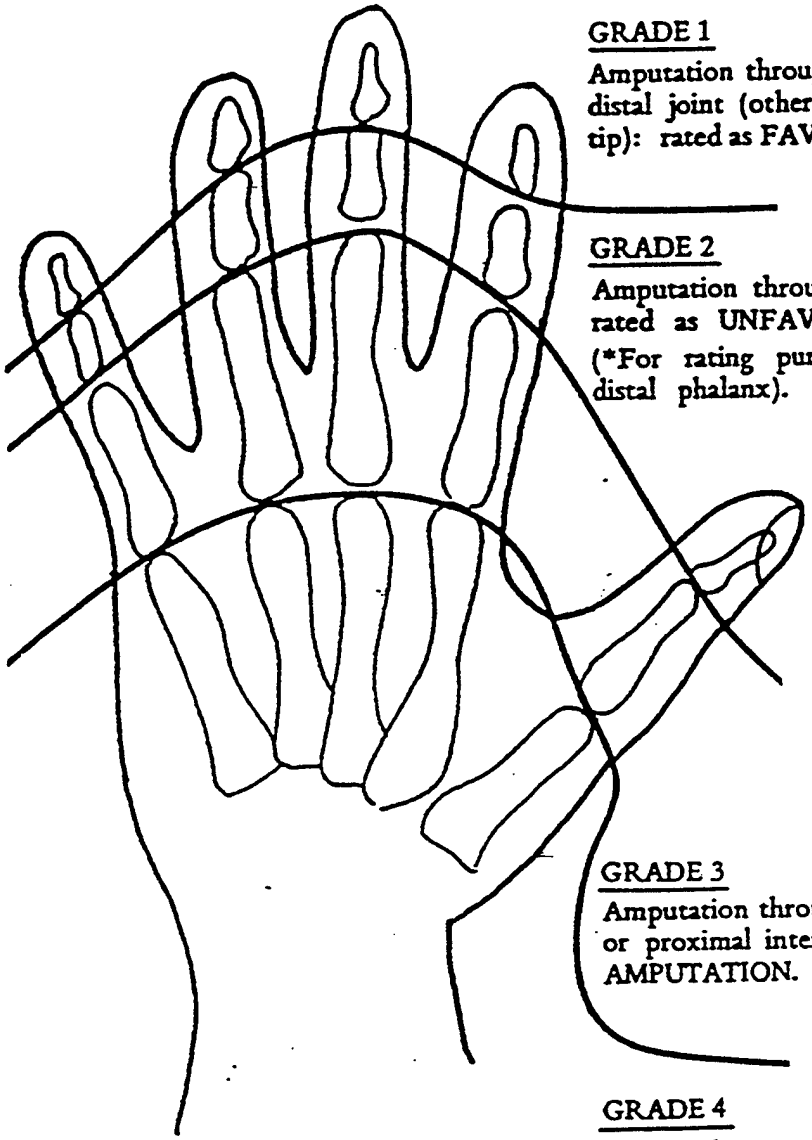


PLATE II

This plate provides a standardized description of ankylosis and joint motion measurement of the lower extremities. The anatomical position is considered as 0°.

Figure 2-1-2 (Plate II)

RATING OF MULTIPLE FINGER DISABILITIES



GRADE 1

Amputation through the distal phalanx or distal joint (other than loss of negligible tip): rated as FAVORABLE ANKYLOSIS.

GRADE 2

Amputation through the middle phalanx* rated as UNFAVORABLE ANKYLOSIS (*For rating purposes, thumb has NO distal phalanx).

GRADE 3

Amputation through the proximal phalanx or proximal interphalangeal joint rated as AMPUTATION.

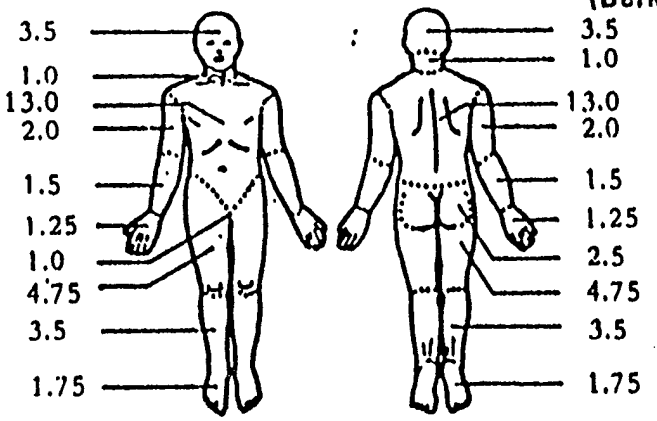
GRADE 4

Amputation or resection of metacarpal bones, more than one-half of the bone lost.

PLATE III

Figure 2-1-3 (Plate III)

* ESTIMATION OF BODY SURFACE AREA
(Berkow)



The diagram at the left provides the basic scheme for estimation of body surface area The table below is for convenient conversion to actual surface area measurement, based upon application to the average 70 kgm. man with a body surface area of 2,636 sq. in. (18.3 sq. ft.).

Body Surface	Percent of body surface	Area	
		Square Inches	Square Feet
Anterior or posterior head	3.5	92	0.64
Anterior or posterior neck	1.0	26	.18
Anterior or posterior trunk	13.0	343	2.38
Anterior or posterior arm	2.0	53	.37
Anterior or posterior forearm	1.5	40	.27
Dorsal or palmar hand & fingers	1.25	33	.23
Buttock	2.5	66	.46
Genitalis	1.0	26	.18
Anterior or posterior thigh	4.75	125	.87
Anterior or posterior calf	3.5	92	.64
Dorsal foot or sole, incl toes	1.75	46	.32

PLATE IV

Figure 2-1-4 (Plate IV)

ALPHABETICAL LISTING OF ANALOGOUS CODES

DIAGNOSIS	CODE 1	CODE 2	CODE 3
A-C SEPARATION	5299	5003	
ACHALASIA	7299	7203	
ACNE	7899	7806	
ALLERGIC RHINITIS	6599	6501	
ANKYLOSING SPONDYLITIS	5099	5002	
ANOREXIA	9499	9410	
ANTERTIOR COMPARTMENT SYN	5299	5312	8723
APHASIA, ORGANIC	8099	9305	
APHONIA, FUNCTIONAL	9499	9402	
APLASTIC ANEMIA	7799	7700	
ATOPIC DERMATITIS	7899	7806	
ATYPICAL DEPRESSION	9499	9405	
AVASCULAR NECROSIS FEMORAL HEAD	5299	5255	
BECHET'S SYN	5099	5002	
BLEPHAROSPASM	8199	8103	
BONE MARROW TRANSPLANT	**RESI**		
BRIEF REACTIVE PSYCHOSIS	9299	9210	
BULEMIA	9499	9410	
CARPAL, BONE INJURY	5299	5212	
CARPAL, TUNNEL SYN	5299	8515	
CEREBELLAR DEGENERATION	8199	8105	
CHAROT-MARIE-TOOTH	8099	8023	
CHONDROMALACIA PATELLAE	5299	5003	
CHRONIC OBSTRUCTIVE LUNG DISEASE	6699	6603	
CHRONIC RENAL INSUFFICIENCY	7599	7502	
COLOSTOMY/ILEOSTOMY	7399	7330	
CONNECTIVE TISSUE DISEASE NOS	6399	6350	
CORONARY ARTERY STENT	7099	7017	
CYCLOTHIA	9499	9405	
DELUSIONAL DISORDER	9299	9208	
DEPRESSIVE DISORDER NOS	9499	9405	
DISSOCIATIVE DISORDER	9499	9410	
DUPUYTREN'S CONTRACTURE (HAND)	5299	52XX	
DYSARTHRIA	8299	8209	
DYSMENORRHEA	7699	7613	
EOSINOPHILIC GRANULOMA (PULMONARY)	6899	6600	
ERYTHEMA MULTIFORME	7899	7806	
ESSENTIAL TREMOR	8199	8105	
FABRY'S DISEASE -	6399	6350	
FEVER of UNKNOWN ORIGIN	6399	6350	
FIBOMYALGIA	6399	6354	
GASTROESOPHAGEAL REFLUX	7399	7346	
GOODPASTURE'S SYN	7599	7502	
GRANUJLOMATOUS COLITIS	7399	7323	
GUILLAIN-BARRE SYN	8199	8011	
HEART TRANSPLANT <2 years	7099	7531	
HEART TRANSPLANT >2 years	7099	7000	

DIAGNOSIS	CODE 1	CODE 2	CODE 3
HEMOPHILIA	7799	7705	
HIDRIADENTITS	7899	7806	
HISTOPLASMOSIS EYE	6099	6011	
HORNER'S SYN	8299	8207	
HOST vs GRAFT REACTION	6399	6350	
HYPERHIDROSIS	7899	7806	
HYPERSOMNIA	8199	8108	
HYPOKALEMIC PERIODIC PARALYSIS	7999	7903	
IDIOPATHIC THROMBOCYTOPENIC PURPURA	7799	7705	
INTERNAL DERANGEMENT OF KNEE	5299	5257	
JOINT PAIN NOS	5299	5003	
LEGG-PERTHES DISEASE	5299	5255	
LIVER TRANSPLANT < 2 years	7399	7531	
LIVER TRANSPLANT > 2 years	7399	7531	7345
LOW BACK PAIN (MECH)	5299	5295	
LYME DISEASE	6399	6350	
LYMPHEDEMA	7199	7121	
MAJOR AFFECTIVE DISORDER	9299	9207	
MALIGNANT HYPERTHERMIA	7999	7900	
MITRAL VALVE PROLAPSE (ARRHYTHIA)	7099	7015	
MITRAL VALVE PROLAPSE (VALVULAR)	7099	7000	
MULTIPLE: MYELOMA	7799	7703	
MYOFASCIAL PAIN SYN	5099	5021	5003
MYOTONIC DYSTROPHY	8099	8023	
NEAR SYNCOPAL. EPISODES	8199	8911	
NEPHROTIC SYN	7599	7502	
NYCTALOPIA (NIGHT BLINDNESS)	6099	6011	
OSGOOD-SCHLATTER	5299	5003	
OSTEOCHONDRITIS DESSICANS	5299	5003	
PACEMAKER	7099	7015	
PANCYTOPENIA	7799	7700	
PANIC DISORDER WITH AGORAPHOBIA	9499	9403	
PANIC DISORDER WITHOUT AGORAPHORIA	9499	9400	
PARALYSIS LOWER EXTREMITY	8599	8520	
PARKINSON'S DISEASE	8199	8105	
PATELLOFERMORAL SYN	5299	5003	
PELVIC FRACTURE	5299	5294	
PELVIC PAIN	7699	7629	
PEYRONIE'S DISEASE	7599	7522	
PILONIDAL CYST	7899	7806	
PLANTAR FASCIITIS	5399	5310	
POST PHLEBITIC SYN	7199	7121	
PRESENILE DEMENTIA (ALZHEIMER'S)	9399	9312	
PSYCHOPHYSIOLOGICAL NERVOUS SYSTEM REACTION	9599	9511	
PSYCHOSIS NOS	9299	9210	
PULMONARY EMBOLUS	7199	6603	
REACTIVE AIRWAY DISEASE	6699	6602	
REFLEX SYMPATHETIC DYSTROPHY (ARM)	8799	8713	

DIAGNOSIS	CODE 1	CODE 2	CODE 3
REFLEX SYMPATHETIC DYSTROPHY (LEG)	8799	8720	
REGIONAL ENTERITIS (CROHN'S)	7399	7328	7323
REITER'S SYN	5099	5002	
RESTRICTIVE AIRWAY DISEASE	6699	6603	
RHABDOMYLOYSIS	5099	5021	
RUPTURED TENDON ACHILLES	5399	5311	
S/P Ca CHEMO/RAD (TUMOR REMISSION)	6399	6350	
SAINT VITUS DANCE	8199	8105	
SARCOIDOSIS (PULMONARY)	6899	6802	
SARCOIDOSIS (SYSTEMIC)	6399	6350	
SCALENUS ANTINCUS SYN	8599	8513	
SCHEUERMANN'S DISEASE	5299	5295	
SCHIZOPHRENIFORM DISORDER	9299	9205	
SCLEROSING CHONLANGITIS	7399	7312	
SCOLIOSIS	5299	5295	
SHOULDER IMPINGEMENT SYN	5299	5003	
SHOULDER SUBLUXATION	5299	5003	
SJOGREN'S SYN	6399	6350	
SLEEP APNEA (NOT OBSTRUCTIVE)	8099	6603	
SLEEP APNEA (OBSTRUCTIVE)	5299	5295	
SOMATOFORM PAIN DISORDER	9499	9402	
SPONDYLOLYSIS/SPONDYLOLITHESIS	5299	5295	
STARGARDT'S DISEASE	6099	6006	
STILL'S DISEASE	5099	5002	
STREP FASCIITIS LOCAL	**RESI**		
STREP FASCIITIS SYSTEMIC	6399	6350	
SUBLUXATION PATELLAE	5299	5257	
SUPERIOR VENA CAVA SYN	7199	7121	
SYNCOPE/SEIZURE ASSOC	8199	8911	
SYNCOPE NOS	8199	8911	
TARSAL TUNNEL SYN	5299	8525	
TENSION HEADACHES	5399	5323	
TENSION HEADACHES (PSYCHOGENlC)	9599	9505	
THORACIC OUTLET SYN	8599	8513	
TIC DOULOUREUX	8299	9205	
TORTICOLLIS	8199	8103	
TOURETTE'S SYN	8199	8103	
TRACHEOSTOMY	6599	6520	
TROPICAL SPRUE	7399	7323	
URINARY INCONTINENCE	7599	7512	
URTICARIA/COLD ALLERGY/ACUTE ALLERGY	7199	7118	
VASCULAR HEADACHES	8199	8100	
VASOVAGAL SYNCOPE	7099	7015	
VESTIBULOPATHY	6299	6204	
VON WILLEB3RAND DISEASE	7799	7705	
WOLFF-PARKINSON-WHITE SYN	7099	7013	

NUMERIC LISTING OF ANALOGOUS CODES

DIAGNOSIS	CODE 1	CODE 2	CODE 3
ANKYLOSING SPONDYLITIS	5099	5002	
BECHET'S SYN	5099	5002	
REITER'S SYN	5099	5002	
STILL'S DISEASE	5099	5002	
MYOFASCIAL PAIN SYN	5099	5021	5003
RHABDOMYLOYSIS	5099	5021	
A-C SEPARATION	5299	5003	
JOINT PAIN NOS	5299	5003	
CHONDROMALACIA PATELLAE	5299	5003	
PATELLOFERMORAL SYN	5299	5003	
OSGOOD-SCHLATTER	5299	5003	
OSTEOCHONDRITIS DESSICANS	5299	5003	
SHOULDER IMPINGEMENT SYN	5299	5003	
SHOULDER SUBLUXATION	5299	5003	
CARPAL, BONE INJURY	5299	5212	
CARPAL, TUNNEL SYN	5299	8515	
DUPUYTREN'S C0NTRACTURE (HAND)	5299	52XX	
AVASCULAR NECROSIS FEMORAL HEAD	5299	5255	
LEGG-PERTHES DISEASE	5299	5255	
INTERNAL DERANGEMENT OF KNEE	5299	5257	
SUBLUXATION PATELLAE	5299	5257	
PELVIC FRACTURE	5299	5294	
LOW BACK PAIN (MECH)	5299	5295	
SCHEUERMANN'S DISEASE	5299	5295	
SCOLIOSIS	5299	5295	
SLEEP APNEA (OBSTRUCTIVE)	5299	5295	
SPONDYLOLYSIS/SPONDYLOLITHESIS	5299	5295	
ANTERTIOR COMPARTMENT SYN	5299	5312	8723
TARSAL TUNNEL SYN	5299	8525	
PLANTAR FASCIITIS	5399	5310	
RUPTURED TENDON ACHILLES	5399	5311	
TENSION HEADACHES	5399	5323	
STARGARDT'S DISEASE	6099	6006	
HISTOPLASMOSIS EYE	6099	6011	
NYCTALOPIA (NIGHT BLINDNESS)	6099	6011	
VESTIBULOPATHY	6299	6204	
CONNECTIVE TISSUE DISEASE NOS	6399	6350	
FABRY'S DISEASE -	6399	6350	
FEVER of UNKNOWN ORIGIN	6399	6350	
HOST vs GRAFT REACTION	6399	6350	
LYME DISEASE	6399	6350	
S/P Ca CHEMO/RAD (TUMOR REMISSION)	6399	6350	
SARCOIDOSIS (SYSTEMIC)	6399	6350	
SJOGREN'S SYN	6399	6350	

DIAGNOSIS	CODE 1	CODE 2	CODE 3
STREP FASCIITIS SYSTEMIC	6399	6350	
FIBOMYALGIA	6399	6354	
ALLERGIC RHINITIS	6599	6501	
TRACHEOSTOMY	6599	6520	
REACTIVE AIRWAY DISEASE	6699	6602	
CHRONIC OBSTRUCTIVE LUNG DISEASE	6699	6603	
RESTRICTIVE AIRWAY DISEASE	6699	6603	
EOSINOPHILIC GRANULOMA (PULMONARY)	6899	6600	
SARCOIDOSIS (PULMONARY)	6899	6802	
MITRAL VALVE PROLAPSE (VALVULAR)	7099	7000	
HEART TRANSPLANT >2 years	7099	7000	
WOLFF-PARKINSON-WHITE SYN	7099	7013	
MITRAL VALVE PROLAPSE (ARRHYTHIA)	7099	7015	
PACEMAKER	7099	7015	
VASOVAGAL SYNCOPE	7099	7015	
CORONARY ARTERY STENT	7099	7017	
HEART TRANSPLANT <2 years	7099	7531	
PULMONARY EMBOLUS	7199	6603	
URTICARIA/COLD ALLERGY/ACUTE ALLERGY	7199	7118	
LYMPHEDEMA	7199	7121	
POST PHLEBITIC SYN	7199	7121	
SUPERIOR VENA CAVA SYN	7199	7121	
ACHALASIA	7299	7203	
SCLEROSING CHONLANGITIS	7399	7312	
TROPICAL SPRUE	7399	7323	
GRANUJLOMATOUS COLITIS	7399	7323	
REGIONAL ENTERITI S (CROHN'S)	7399	7328	7323
COLOSTOMY/ILEOSTOMY	7399	7330	
GASTROESOPHAGEAL REFLUX	7399	7346	
LIVER TRANSPLANT < 2 years	7399	7531	
LIVER TRANSPLANT > 2 years	7399	7531	7345
CHRONIC RENAL INSUFFICIENCY	7599	7502	
GOODPASTURE'S SYN	7599	7502	
NEPHROTIC SYN	7599	7502	
URINARY INCONTINENCE	7599	7512	
PEYRONIE'S DISEASE	7599	7522	
DYSMENORRHEA	7699	7613	
PELVIC PAIN	7699	7629	
APLASTIC ANEMIA	7799	7700	
PANCYTOPENIA	7799	7700	
MULTIPLE: MYELOMA	7799	7703	
HEMOPHILIA	7799	7705	
IDIOPATHIC THROMBOCYTOPENIC PURPURA	7799	7705	
VON WILLEBRAND DISEASE	7799	7705	
ACNE	7899	7806	
ATOPIC DERMATITIS	7899	7806	
ERYTHEMA MULTIFORME	7899	7806	
HIDRIADENTITS	7899	7806	
HYPERHIDROSIS	7899	7806	

DIAGNOSIS	CODE 1	CODE 2	CODE 3
PILONIDAL CYST	7899	7806	
MALIGNANT HYPERTHERMIA	7999	7900	
HYPOKALEMIC PERIODIC PARALYSIS	7999	7903	
SLEEP APNEA (NOT OBSTRUCTIVE)	8099	6603	
CHAROT-MARIE-TOOTH	8099	8023	
MYOTONIC DYSTROPHY	8099	8023	
APHASIA, ORGANIC	8099	9305	
GUILLAIN-BARRE SYN	8199	8011	
VASCULAR HEADACHES	8199	8100	
BLEPHAROSPASM	8199	8103	
TORTICOLLIS	8199	8103	
TOURETTE'S SYN	8199	8103	
CEREBELLAR DEGENERATION	8199	8105	
ESSENTIAL TREMOR	8199	8105	
PARKINSON'S DISEASE	8199	8105	
SAINT VITUS DANCE	8199	8105	
HYPERSOMNIA	8199	8108	
NEAR SYNCOPAL. EPISODES	8199	8911	
SYC0PE/SEIZURE ASSOC	8199	8911	
SYNCOPAL NOS	8199	8911	
HORNER'S SYN	8299	8207	
DYSARTHRIA	8299	8209	
TIC DOULOUREUX	8299	9205	
SCALENUS ANTINCUS SYN	8599	8513	
THORACIC OUTLET SYN	8599	8513	
PARALYSIS LOWER EXTREMITY	8599	8520	
REFLEX SYMPATHETIC DYSTROPHY (ARM)	8799	8713	
REFLEX SYMPATHETIC DYSTROPHY (LEG)	8799	8720	
SCHIZOPHRENIFORM DISORDER	9299	9205	
MAJOR AFFECTIVE DISORDER	9299	9207	
DELUSIONAL DISORDER	9299	9208	
BRIEF REACTIVE PSYCHOSIS	9299	9210	
PSYCHOSIS NOS	9299	9210	
PRESENILE DEMENTIA (ALZHEIMER'S)	9399	9312	
PANIC DISORDER WITHOUT AGORAPHORIA	9499	9400	
APHONIA, FUNCTIONAL	9499	9402	
SOMATOFORM PAIN DISORDER	9499	9402	
PANIC DISORDER WITH AGORAPHOBIA	9499	9403	
ATYPICAL DEPRESSION	9499	9405	
CYCLOTHIA	9499	9405	
DEPRESSIVE DISORDER NOS	9499	9405	
ANOREXIA	9499	9410	
BULEMIA	9499	9410	
DISSOCIATIVE DISORDER	9499	9410	
TENSION HEADACHES (PSYCHOGEN1C)	9599	9505	
PSYCHOPHYSIOLOGICAL NERVOUS SYSTEM REACTION	9599	9511	
BONE MARROW TRANSPLANT	**RESI**		
STREP FASCIITIS LOCAL	**RESI**		